

THE
AMERICAN PRACTITIONER:

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

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THE AMERICAN PRACTITIONER.

OCTOBER, 1878.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than anything else.—RUSKIN.

Original Communications.

TRUE AND FALSE EXPERTS.

BY J. W. GORDON, M. D., LL. D.

(Continued from page 141.)

It has been already said that society has a right, upon just terms, to the use of all the knowledge, learning and ability of its members. Through its organ, the state, it may, in emergencies that require, fairly demand them. The members of the medical profession are subject to this common law, and the same conscription may reach them, that, from time to time, reaches the professors of all other special experiences and knowledge. It has a right to ask him that knows to instruct, and him that sees to lead it, where the common knowledge and sight fail it. There is no department of the government of any civilized state, that may not, at any moment, be forced to ask the aid, and follow the guidance of some man of special science, or fall short of its duty. The medical man is, perhaps, more frequently needed than most other specialists; and touches, in the exercise of his functions, in public admin-

istration, quite as many and important relations and interests as any other.

It will scarcely be denied by one who has considered the subject, that there ought to be in every locality a number of medical men, learned in the science, and experienced and wise in the art of medicine and surgery, sufficient not only to meet all the wants of the people in private practice, but also all the just and necessary ends of the government. Such a body of doctors would, in the conscientious and fair exercise of their faculties, regard it as a part of their professional duty to thoroughly study and determine the medical topography of their respective fields of practice; ascertain the diseases due to the peculiarities of the place, as well as the modifications of others arising from the same influences; and generally to fix upon a well defined basis of observed facts all the conditions of the neighborhood tending to health or disease, as well as the modes of their operation. The results of such a study in every vicinity would be, from time to time, brought together in the several county, district and state medical societies; and out of them would at last be constructed, by some patient and competent worker, a true medical topography of the entire state; and the local and permanent influences affecting the public health, in every part of the state, would become a portion of the permanent and certain knowledge of the profession. Such a knowledge, added to the doctrines of health and disease, as taught by our schools of medicine, would prepare the doctor more readily and thoroughly to estimate the nature and force of any temporary adventitious morbid causes which might arise in his vicinity, whether resulting from natural or human agency. In this way, the general and constant conditions of life and health, or of sickness and death, would become to the medical investigator the fixed measure of the particular and transient conditions affecting the same. Without having acquired some knowledge of these uniform and established conditions constantly operating to impair health and destroy life in his field of practice, and making it the basis of his special investigations in regard to

every particular case, the doctor may intend well in his effort; but, if successful, and as far as successful, he will be debtor to chance rather than to science and skill.

So much has been said with reference to the preparation necessary to the function of the investigator or inspector, which is the first relation, that as expert, the medical man may sustain to his government. In the improvement of the state, and the development of its resources, whether under the immediate exercise of its authority, or by corporations or individuals, it not unfrequently happens, unavoidably or negligently, that conditions are created which are, or are supposed to be, injurious to the health of the people where such conditions exist. It then becomes necessary to determine what may be the truth in regard to the subject. A commission of medical men is appointed and charged by public authority with the investigation of the matter. Their decision involves the gravest consequences,—the public health on the one hand, and the progress, and, it may be, the existence even of a great public or private enterprise, on the other. Such commissions are common in all civilized and enlightened lands. Our state has called them into existence, and been guided by their decisions in matters of the highest importance. Thus, in the construction of the Wabash and Erie Canal, a vast reservoir was created in Clay county; and, though covered with forest and vegetation, it was yet filled with water. Loud complaints were soon made against it, as a great public nuisance, ruinous to the health and dangerous to the lives of the people in its neighborhood. A commission of learned physicians was appointed to inspect it, investigate the truth of the complaints of the people, and report the result of their labors to the governor. An inspection and report were accordingly made; but, before further action was taken by those in authority, a mob of citizens cut the embankments and drained the reservoir. The object of referring to this instance of medical inspection and investigation here, is not, however, to exhibit the result; but, on the contrary, to illustrate the nature and importance of the public

duties to which medical men may at any time be called; and so to enforce, by an example, the necessity for that antecedent preparation and knowledge of special topography with respect to health and disease, which can alone prepare them for their adequate performance. The commission, in the foregoing case, could not have taken one intelligent measure in pursuit of the object of their organization, without first settling, at least in a degree, the sanitary condition of the locality of the reservoir, prior to its construction, so far as that had depended upon constant local causes. After this condition and its causes had been ascertained, the change produced upon the health of the neighborhood by the reservoir could be investigated and determined with some certainty. *The importance, too, of having the antecedent condition of the place ascertained before the necessity arose for the labors of the commission, can not be overestimated; for, after the public mind had become excited and inflamed by the construction of the reservoir, and the evils supposed to arise from it had become known, every means of ascertaining the truth in regard to the state of health that went before it, would be impaired or lost. And the same must, in a measure, be true in other cases involving similar questions. After the creation of a nuisance, real or imaginary, in any community, the evils of the past are forgotten, while those of the present are almost always attributed to it and exaggerated. The necessity of a State Board of Health becomes apparent in the presence of such facts. One, or a few men in a state, however great, public spirited, and laborious they may be, are not equal to the work of determining its medical topography and ascertaining the local and abiding forces that operate to sustain or destroy health and life therein. It must be the task of all, in pursuance of a common design and actuated by a common spirit. When it shall be attained, however, then can society act intelligently and efficiently under the direction of its doctors in the removal or diminution of the natural causes of disease, and the abatement of every adventitious nuisance. The state, acting upon the maxim,—*Salus populi suprema lex*

est,—must, sooner or later, employ the medical profession in the pursuit of this great object, and persist in it until its final and complete attainment. But, even if the state in its ordinary administration should still further neglect so great an object of social organization, may we not look to the profession of medicine itself to accomplish it without aid, for the benefit of the people, and for its own perfection and glory?

But the medical man is more frequently called upon as an expert investigator of the special facts of cases involving the infliction of a private injury to one person by another, or the commission of a public offense, than of the more general conditions and circumstances affecting the public health in a given locality. Here, again, he must proceed as before, from the general and constant facts of the situation, and those immediately preceding it, to such as are special and transient. If he is to determine between a surgeon and his patient, whether the *latter* has been injured by the malpractice of the *former* in the treatment of a broken leg, it is necessary for him to know, first, what was the condition of the limb before it was broken, the age, state of health, and constitutional peculiarities of the patient, and very many like matters, any one or more of which, when understood, may be sufficient to account for all the injury laid at the door of the surgeon. It is no purpose of this paper to do more than suggest these antecedent and attendant conditions of the fracture, which in no way depend on it; but which by their own force and tendency may have retarded, marred, or altogether prevented a cure, which, with the same treatment, under different conditions, would certainly have been effected. No man ought to undertake the examination of any such case, with a view to becoming a witness on the one side or the other, without first resolving to determine every condition preceding and concurrent with the injury and its treatment; and whether, and how, and how far the same was favorable or unfavorable to its complete cure. When these are ascertained, as far they may be, he may then proceed to consider the limb itself, and how, and to what extent it falls short of being in as good condition as

before the injury. Having settled these matters, he is prepared to hear an account of the particulars of the treatment; and of any accident or circumstance that may have tended to prevent or secure its complete success. Here will be the proper place to consider any willful or negligent behavior of the patient that may have injuriously affected the treatment. No fact should be overlooked in the account, for the opinion which the expert witness is to give upon the facts ascertained by the expert investigator will derive its force entirely from them. Should any material fact be omitted, its absence may lead to a false conclusion, and become the foundation of a false verdict and an unjust judgment. While, on the other hand, should any immaterial fact find its way into the statement, which leads to the conclusion of the expert witness, it may readily be eliminated by a judicious cross-examination; and even if it is not so eliminated, it ought in no wise impair the weight of the opinion, provided it is proved. The only ill consequence resulting from the introduction of an immaterial fact into the case, on which the opinion of an expert witness is taken, is the danger of failing to prove it. If that should be the case, and the cross examination fail to disclose its immateriality, then the court or jury may properly say that, as the case on which the expert's opinion rested was not entirely proved, the opinion itself is worthless. The expert investigator should, however, always observe and preserve every fact which the most comprehensive view of the whole case may regard as material. If any fact so embraced in the case turns out to be without value, it may be sifted out by an adequate cross-examination. Its absence, if material, can not be so readily supplied; indeed, not at all.

It sometimes happens that those not well instructed in medicine, involve themselves in strange contradictions from not knowing the value and relation of facts; and, at others, from not preserving all the facts. A case happened a few years ago in central Indiana, illustrating this observation in both its branches. A young married lady was thrown from her horse, in the fall breaking both bones of her right leg,

eight or ten inches above the ankle-joint. She was pregnant, being about five months gone, at the time of the accident. A surgeon was called, who adjusted the bones of her limb, and applied a splint, remarking, in the presence of witnesses, at the time, that it was too short. Next day he brought another splint which, trying upon the limb, he declared to be too long; and added, that he would have to make the first do. He did; but when his patient got about, it was found that her leg was both shortened and crooked—the foot being turned inwards, and the limb at the seat of the fracture bowed outwards. She limped badly—in short, was a cripple for life. Dissatisfied with the result, she sued the surgeon. He made a vigorous defense; but failed to embrace in it all the facts of the case. He relied, in his opening to the jury, upon two facts or conditions, existing before the fracture, and during the treatment. These, it was insisted, counteracted and thwarted the treatment, producing the deformity and lameness that he did not deny existed. These sinister conditions were, scrofulosis and pregnancy. But even his own experts admitted that pregnancy, during its existence, counteracted and held scrofula in abeyance. And then it was satisfactorily proved that the fracture had speedily and completely united. Neither scrofulosis nor pregnancy had prevented a solid bony union. Besides, she had been delivered at full time of a well-developed child, perfect in all its bones. The grounds of defense were contradictory; and for such a result the defendant was utterly unprepared. He abandoned it; and in the midst of the contest set up another. It was now insisted that the cure was as perfect as ought to be looked for or required under the best treatment and most favorable circumstances; and, at all events, that, if anything was wanting in the result, it was due to her own negligence in getting up too soon, and walking on the limb before the union was perfect. It was the misfortune of this defense to have to face that first relied on, and to have no facts of its own to support it. It was seen to be a most unfortunate shift; and the jury did not believe it to be true. The facts of the case had not been all collected and submitted

to defendant's expert witnesses, before the line of defense was adopted; and the defendant, as a consequence of his neglect, had a verdict rendered against him for \$4,750. This verdict, it is true, was set aside, and the case ultimately compromised; but the case nevertheless illustrates the necessity in every instance of collecting all the facts, and carefully arranging the prosecution or defense, so as to harmonize it with them all. If counsel have not received a medical education, they should never adopt a theory of their case, whether in the prosecution or defense, without first having carefully collected every fact that, in any conceivable view, may become material, and submitted them to wise experts who know the relations and value of each, and taken their judgment upon what may, or may not be the conclusion to which they lead.

It is not the purpose of what is here said to give directions for making inspections or investigations in any department of professional duty. Medical men are better informed than to need it. They understand the scope and details of such matters already. It is only necessary to awaken their attention, and stimulate their diligence, to make every investigation thorough and complete that may be committed to them. And this is necessary; for in these respects the public trials for homicide, infanticide and abortion constantly furnish many illustrations of lazy negligence, and now and then one of incompetency and ignorance. There is nearly always manifest in these cases an inexcusable want of thoroughness; and many an offender owes his acquittal of the highest crime known to our code to the insufficiency of a post mortem examination. A case occurred in this county within a year past that may serve for illustration. A woman—the wife of a poor laborer—died one Sunday evening suddenly, and with all the symptoms of poisoning by strychnia. She was up and about the house until seven o'clock; but, being a sufferer from neuralgia and accustomed to take medicine to mitigate her misery, she received from her husband and took a dose of a brownish mixture, which he said he had received from a druggist, who called it a neuralgia-powder. It was dissolved

in water and drunk from a common tumbler. Within half an hour after taking it, she was seized with spasms and all the symptoms of poisoning by strychnia. There was no cessation of these symptoms for two hours and a half, at the end of which time she died. The post mortem examination was well enough as far as it went, but did not extend to all the vital organs—spending itself on the stomach and bowels, liver, lungs, heart and nervous centers. Beyond these it did not extend. The kidneys and pelvic viscera were not examined, although her regular medical attendant testified that she had been a constant sufferer from disease of both. Here was ground for an hypothesis that death resulted from natural causes; and expert testimony of high character gave it great probability. But the great failure in the post mortem proceedings adopted to prove the cause of death, was not due so much to any omission in the post mortem examination proper, as to the measures taken to determine whether the deceased had taken strychnia or not. The evidence showed that the husband had bought both morphia and strychnia the same day. The description given by the deceased of the taste and immediate effects of the potion tended to prove that it contained strychnia. All subsequent symptoms, the mode of death, and post mortem rigidity of the body, went to establish the same fact. But no time was allowed, or taken by the chemist who undertook the analysis of the stomach and its contents with other parts of the remains, at all adequate to the accomplishment of the important duty. The result corresponded with the hurry. No strychnia was discovered, while morphia was, thus adding another element of confusion to the already tangled tissue of the case. The analysis not only fell short of clearing up the difficulties of the case, failing to confirm the conclusion of the husband's guilt, to which the other circumstances strongly tended; but by its negative result, added some grains to the doubts in his favor.

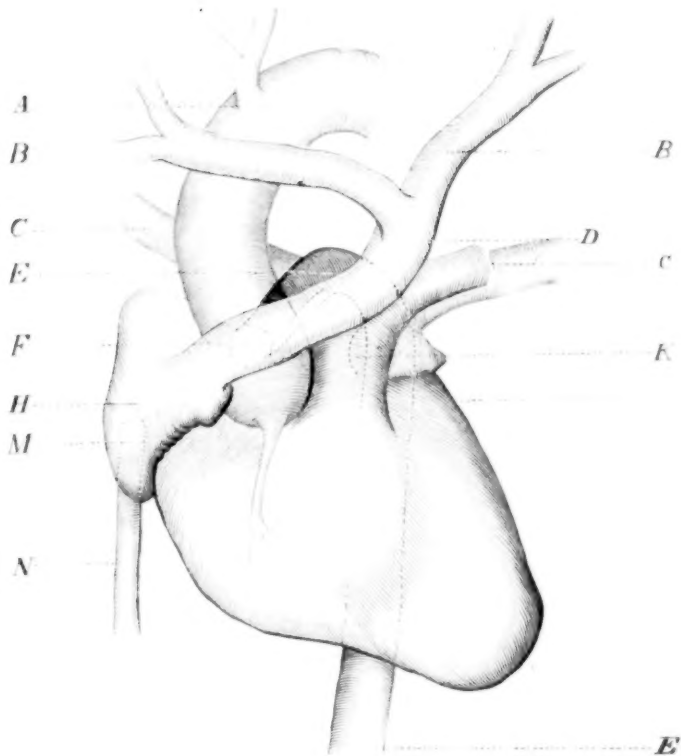
But the chief and crowning failure in point of thoroughness occurred in the use made of the tumbler from which, it was

insisted, the fatal draught had been taken. This was produced at the time of the coroner's investigation by the husband, who said it was just as left after the medicine was taken; and called attention to the brownish stains still thickly adherent to its inside, and said that that was the color of the medicine he last gave his wife. It seems that it never occurred to the coroner, or any one else in connection with the prosecution, to rinse the tumbler, and analyze the washings; for the only use made of it by the prosecution, was to exhibit it to the jury, in connection with a phial of muriated tincture of iron found in defendant's house; and, without any proof of the fact, insist that the defendant had mixed enough of that tincture with the strychnia which killed his wife, to discolor and conceal it. The defendant's counsel, after satisfying himself, while the trial was going on, that the brownish stains on the inside of the tumbler contained a large proportion of strychnia, in his final argument to the jury held up the discolored vessel and told them that, if, as contended by the prosecution, the dose given from it had contained strychnia, the fact could have been readily settled by rinsing it, and analyzing the washings. There would have been no difficulty in forever settling the question by such a procedure. The failure to adopt it had left the case fairly exposed to just criticism and grave doubts; and so the defendant ought to be acquitted. In fact, to convict him upon such evidence, when so many sources of doubt that might readily have been removed were left standing, by the mere negligence of those acting for the state, would be to establish a precedent dangerous to the citizen, and fatal to the fair administration of justice. The jury found the defendant not guilty, and he was discharged. It is proper to add, that a subsequent analysis of the rinsings of the tumbler gave crystals of strychnia sufficient for hundreds of satisfactory tests; and, therefore, quite sufficient to prove that the wife had taken the poison. It is unnecessary to enforce the moral illustrated by the case. It is an old one, but vital in all pursuits whether public or private:—Diligence in business.

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EXTROPHY OF THE HEART.

(DR. HODGEN'S PAPER.)



A.—Aorta. B B.—Venæ Innominatæ. C C.—Pulmonary Veins.
D.—Vena Cava Descendens. E E.—Vena Cava Ascendens, opening
into Vena Cava Descendens at F. F.—Opening of Ascending V. C.
H.—Right Auricular Appendix. K.—Pulmonary Artery. M.—Open-
ing of Hepatic Vein into Right Auricle. N.—Hepatic Vein.

EXTROPHY OF THE HEART.

BY JOHN T. HODGEN, M. D.

Mrs. —, a German, at term, attended by Dr. Bernays, in February, 1864, gave birth to a healthy living child. The heart was found entirely outside of the chest, the vessels passing from the chest through an opening in the median line. The heart was not covered by pericardium, and stood with its apex pointing forward, downward and to the left. The organ pulsated rapidly but regularly; with each elongation of the organ, the apex was pushed forward and swept to the left. The contractile wave, beginning at the auricles, swept over the ventricles.

On the third day after birth, the heart had lost its red color, being covered by a thick layer of fibrinous matter. This assumed a yellowish tinge, became softened, and was detached, leaving the muscular tissue of the heart exposed and dry, or less moist than it had been.

On the fourth day, the auriculo-ventricular fissure became deeper, and presented a ragged-looking groove, which was deepened by the thickening of the borders.

On the fifth day the child died, and twelve hours after a post mortem examination was made in the presence of Drs. Hammer and Rogers.

The body was about the average size, and perfect except as noted. The distance between the inner ends of the clavicles—*i. e.*, the sterno-clavicular articulations—was $1\frac{3}{4}$ inches. The first and second pieces of the sternum were divided, leaving a space like the letter U; this cleft extended to a point opposite the articulation of the fourth rib with the sternum, the opening being one inch in diameter.

As it approached the opening, the skin was continuous with a dense fibrous structure which was found attached to the great vessels—(*i. e.*, the pulmonary artery, the aorta, and vena cava)—at a point corresponding to that at which the

pericardium is attached. This connection served to hold the vessels in position, as they escaped through the opening in the more dense structures. The heart was of normal size, but more elongated, the apex being formed by the *right* ventricle.

On opening the chest no space was found for the heart, the mediastinum being central, with the phrenic nerves passing down in it near each other; the lungs filled the entire cavity, and each lung had three lobes. The hepatic veins ascended as a long single vessel to the right of the median line, in the mediastinum, to the opening in the sternum, and entered the right auricle of the heart on its right side and behind the opening for the ascending cava.

The ascending cava passed up the *left* side of the median line in the mediastinum, received the descending cava, and entered the right auricle by a sinuous passage, at first passing downward, then turning at a right angle to the right entered the auricle. The descending cava, half an inch long, situated to *left* of median line, received the innominate of right side, which was long and crossed the median line toward the left. The left innominate vein passed directly downward, and joining the right, on the left of the median line, formed the descending cava. A single pulmonary vein, formed by the union of a vein from each side, entered the *left* auricle. The pulmonary artery, having but two semilunar valves at its beginning, took its origin from the right ventricle; while immediately to its right, and from the right ventricle also, came the aorta. A free opening existed between the right and left ventricles. No foramen ovale existed between the right and left auricles, the septum being perfect; no ductus arteriosus.

Extensive and recent adhesions, formed by recently deposited lymph, showed the existence of peritonitis.

ST. LOUIS, MO.

PUERPERAL FEVER AND ITS SUPPOSED ALLIANCES.

BY THOMAS CHESNUT, M. D.

Sydenham effected the revolution in the treatment of small-pox, by substituting free ventilation into the chamber of the sick, with sponging and ablutions of the entire person, with cool drinks and a cool regimen, which proved so beneficial and grateful to his patients, over the foul and pestilential air of the sick room, with the heating treatment practiced by the ancients. This truly valuable contribution to the practice of the healing art clearly entitled him to the gratitude of the age in which he lived. But vastly more important to all succeeding ages was the discovery by Dr. Jenner of the prophylactic and modifying properties and powers of the cow-pock virus, which discovery has entitled him to the first rank among the greatest benefactors of the human race. As many of the brightest and most enlightened minds of the profession are at present employing their best energies in pressing their inquiries into the cause or causes giving origin to that much dreaded disease commonly called puerperal fever, may we not hope that their untiring efforts will, ere long, meet with a reward which will more than compensate them for their benevolent labors.

Dr. Playfair, in his late *System of Midwifery*, says:—"The whole tendency of recent investigation is daily rendering it more and more certain that obstetricians have been led into error by the special virulence and intensity of the disease; and that they have erroneously considered it to be something special to the puerperal state, instead of recognizing in it a form of septic disease practically identical with that which is familiar to surgeons under the name of pyemia or septicemia."

Should the theory that puerperal fever is a septic disease, liable to be caused by the inoculation of ichorous or putrid animal matters conveyed from without or generated within the patient, producing thereby a morbid action, prove by the

test of experience to be true, it would be an advanced step in the right direction, as it would serve to bring this formidable malady more completely under the control of preventive measures and remedial agencies, than would likely to be the case under the specific theory.

That puerperal fever, when it assumes a malignant type, is among the most contagious of diseases, is a fact which will scarcely be doubted by any one at the present time.

Dr. Gordon, in his report of the epidemic at Aberdeen, in the years 1789 to 1793, says, "that he could foretell what women would be attacked upon hearing by what midwife they were to be delivered, and that in almost every case his prediction was verified." (*Journal of Medical Science*, 1846, page 269.) Dr. Armstrong, in his essay on the Sunderland epidemic, mentions several instances of confinement of the disease to one man's practice. The same fact is noticed by Drs. Ramsbotham, Lee, Gooch, Robertson, Hutchinson and Blundell.

Again Dr. Gordon says:—"The disease seized such women only as were visited or delivered by practitioners, or taken care of by nurses, who had previously attended patients affected with the disease. I had evident proofs that every person who had been with a patient in the puerperal fever became charged with an atmosphere of infection, which was communicated to every pregnant woman who happened to come within its sphere. It is a disagreeable declaration for me to mention that I myself was the means of conveying the infection to a great number of women."

Dr. Leishman, in his *Midwifery*, page 689, says:—"Of all the modes in which fever may be generated in a puerperal woman, that by means of septic absorption, for which her condition at the moment offers peculiar facilities, is we now believe decidedly the most frequent, although it is only of late years that it has come prominently into action." Leishman again remarks:—"The doctrine of contagion is, in regard to septicemic puerperal fever, now all but universally received; but in regard to other varieties, and the allied inflammatory

affections, the question presents itself for solution under conditions of greater difficulty. We have already expressed our opinion that although scarlatina may run its course in a woman who has been lately delivered, without development of any marked symptoms beyond those of the specific fever, such cases very frequently pass into a condition which is identical with puerperal fever." Again he says:—"Although the poison may produce in puerperal women scarlatina and nothing more, this is not the rule, but a rare exception." And again: "It matters but little in practice whether we say it is modified scarlatina or modified puerperal fever, so long as we recognize the affinity which subsists between the two." He continues: "But beyond this we are convinced that from the contagion thus developed puerperal fever may be again and again reproduced; and, if we are right in this, the same remarks will apply to the other septic fevers."

Dr. Playfair, in his *System of Midwifery*, on page 519, says:—"According to this theory, the so-called puerperal fever is produced by the absorption of septic matter into the system through solutions of continuity in the generative tract, such as always exist after labor. It is not essential that the poison should be peculiar or specific; for just as in surgical pyemia, any decomposing organic matter, either originating within the generative organs of the patient herself, or coming from without, may set up the morbid action."

The leading purpose which has prompted me to undertake the task of compiling from the recorded opinions contained in standard authors, and medical writers of acknowledged ability, such selections as may serve to show the identity or alliance that appears to exist between the poison of puerperal fever and erysipelas, is the fact that such connection is both theoretically and practically denied by some members of the profession.

In the *American Journal of Medical Sciences*, April, 1846, is contained a very elaborate and ably written paper, contributed by Dr. Kneeland, in which the connection between puerperal fever and erysipelas appears to be pretty clearly

established. The doctor assumes, "that if puerperal fever and erysipelas depend upon the same cause, and are propagated in the same manner, we ought to find well authenticated instances of the former giving rise to the latter disease, and *vice versa*." In evidence of the correctness of this assumption, he adduces the following instances of the contagion of erysipelas giving rise to puerperal fever: Mr. Hutchinson, of Nottingham, "mentions the fact of two surgeons meeting half way to visit a patient laboring under extensive erysipelas of the leg. One of these gentlemen attended a woman in labor the same evening, who died of puerperal fever; the other, in the two following days, attended three women, all of whom he lost in the same manner." In the Edinburgh Medical and Surgical Journal, Mr. Renton states that, "in a woman who died of puerperal fever in his practice, a constant communication had been kept up with the next house, in which were two children ill of erysipelas."

Dr. Ingleby, of Birmingham, gives the following cases:—"A practitioner attended a lady affected with erysipelas, and made incisions into the part. He shortly after attended a lady in labor, and on the same evening a second; both died of puerperal fever. A third fatal case followed, and a fourth was attacked but recovered. The second case was examined after death by himself and assistant, both of whom attended midwifery cases without changing their clothes; these women died of puerperal fever." Two surgeons visited a case of erysipelas, and went immediately after to a labor with placenta presentation; the patient died of puerperal fever. One of these surgeons attended a second confinement within a period of seven hours from the first; this patient was attacked with the fever, and narrowly escaped with her life; the woman who attended and nursed her became the subject of erysipelas. Another surgeon, after opening an erysipelatous abscess, attended a woman in labor, who died of puerperal fever.

In the Edinburgh Medical and Surgical Journal, 1839, Mr. Siders "relates the case of Mrs. C., who died of puerperal fever after confinement with her first child; her maid was, on

the fourth day after her death, seized with diffused erysipelatous inflammation; the husband, at the same time, had sore throat." . . . "Mrs. M. died of puerperal fever on the sixth day after her sixth confinement. Within a week five cases of erysipelas occurred in the family. The sister-in-law had erysipelatous sore throat; the mother-in-law and son had erysipelas of the head and face."

Playfair says in his *Midwifery*, p. 522:—"The dependence of the two on the same poison, was in one instance curiously shown by the fact of the child of a patient who died of puerperal fever, dying from erysipelas which started from a slight abrasion produced by the forceps."

Bedford, in his *Principles of Obstetrics*, page 683, says:—"The testimony is ample, showing a connection between puerperal fever and erysipelas. The two diseases may prevail simultaneously in the same neighborhood; or, if erysipelas alone prevail, a third party may communicate from a patient affected with it puerperal fever to a woman recently delivered."

Dr. Aitken, in the *Science and Practice of Medicine*, page 362, says:—"Erysipelas and puerperal fever are interchangeable diseases, the one being able to induce the other by personal contact."

Dr. Underhill quotes Dr. Barnes as saying:—"I do not believe that women in the pregnant or parturient state *catch* the disease from each other in the sense that they contract measles, scarlatina, etc., for example. But I do believe that the puerperal or parturient woman may be infected with the disease by direct contact of the poison of decomposing animal matter; the hand being the agent most likely to carry the poison."

Dr. John Dawson, of Jamestown, Ohio, who was a good thinker, a good observer, and a respectable writer, gave to the profession, through medical journals, a well digested and accurate history of the character and symptoms of the epidemic of puerperal fever and erysipelas as they prevailed in the Miami Valley, during the winter and spring of 1844. Dr. Minor, speaking of Dr. Dawson in relation to that epidemic, says:—"The doctor's most valuable observations at that time,

however, were as to the connection existing between the epidemic erysipelas and the puerperal fever, which was then very prevalent in Warren and Montgomery counties. The doctor gives quite a number of cases to the point, and is fairly entitled to the credit of having been the closest observer and student of the connection of the two diseases in that celebrated epidemic. Dr. Dawson's conclusions are then entitled to due weight; they are as follows:

"First, that the disease prevailed at the same time that erysipelas was prevailing, and subsided on the disappearance of that malady; second, that the premonitory symptoms were like those of erysipelas, consisting of a chill, followed by more or less fever and sore throat; third, that in several instances erysipelas made its appearance on the skin during the progress of the malady, as was the case with several families witnessed by Dr. Van Tyle and others; fourth, instances occurred in which erysipelas was contracted from puerperal females by their nurses; fifth, that the children delivered, in almost every instance, were taken shortly after birth with high fever, erysipelas of the scalp and face, and died."

Dr. Dawson, in conclusion, remarks that—"Facts of this character must be regarded as going to settle, in a tolerably decided manner, the position that the fatal disease which occurred to the puerperal females, to whom I have alluded, is identical with the epidemic erysipelas, which prevailed at the time in the neighborhood."

But the gentleman who has devoted more time and expended more labor and thought than any other man, perhaps, in this country, in his inquiries into the nature and cause or causes of puerperal fever and its connection with erysipelas, is Dr. Thomas C. Minor, of Cincinnati, Ohio. In the Cincinnati *Lancet and Observer* for October, 1874, he speaks thus in regard to the result of his researches:

• "If, after the mass of figures we have waded through, we have not been able to learn something regarding puerperal fever and erysipelas, it would be surprising. The study of the census tables of 1870, although they fail to give many

decided signs of the connection between puerperal fever and erysipelas, still teach a valuable lesson. It is this:—in any place where erysipelas is found, there will be found puerperal fever. In the absence of more minute particulars than are furnished by the census tables, we are constrained to only give a general conclusion. This conclusion is based on the following propositions:

“1. Erysipelas and puerperal fever seem to prevail throughout all the states; 2. Any marked increase in any one locality of one disease, seems to be accompanied by a corresponding increase of the other; 3. Where history of past epidemics of either disease are obtainable from any of the states, the seeming connection of the two diseases was noticed by physicians at the time of such epidemic, and remarked on; 4. For these reasons we are, I think, justified in concluding that there is an intimate connection existing between puerperal fever and erysipelas.”

The doctor continues;—“If we now study the tables of the late epidemic in this city (Cincinnati), we can further strengthen our belief, and arrive at an even more definite conclusion in regard to this subject, by basing ourselves on the following propositions:—1. The two diseases prevailed as epidemics, at the same time, in the same localities; 2. Where an isolated death from puerperal fever was noted, outside of the infected districts, a corresponding death from erysipelas was noted in the same locality: this was almost invariably the case; 3. Infants die of erysipelas shortly after or before their mothers die of puerperal fever; 4. A few physicians attending puerperal fever cases and erysipelas cases at the same time, as exhibited by the ‘death register,’ were the most unfortunate in their practice; 5. Physicians having large obstetrical practice, who are known to be believers in the doctrine enunciated regarding the connection of puerperal fever and erysipelas, make an exhibit of but few death certificates from either cause.”

Dr. Minor remarks thus:—“It is a sad commentary on this last epidemic, that a few men who attended cases of erysipelas and puerperal fever promiscuously, should have been most

unfortunate in their practice. On the contrary, we notice some physicians having a large practice, who lost not more than one or two cases of puerperal fever, and no erysipelas cases at all." The doctor adds:—"I think the majority of our physicians refuse to attend confinement cases when they have erysipelas or puerperal fever cases on their hands." He further says:—"I am a firm believer in the doctrine so strongly urged by Dr. Tilbury Fox, of London, that erysipelas and puerperal fever are entirely dependent on a common poison."

Now, if the doctrine of the contagious and transmissible character of the disease be true, and the evidences already adduced in its favor are certainly very strong if not quite conclusive, is it not reasonable then to suppose that the spread of puerperal fever by contagion may be held quite as securely, if not even more effectually, within the control of the profession, than is the spread by contagion of small-pox at the present time? Persons of every age and sex are liable to contract the latter, while parturient women are alone liable to become the subjects of the former disease. It hardly need to be stated that a physician, while in attendance on a patient suffering from either puerperal fever or malignant erysipelas, should refuse to attend confinement cases during such attendance; and not afterward until ample time has been allowed to free his person and apparel from the poison, by the use of such means as are well known to every physician, before resuming his obstetrical practice. For the consideration of such, if any there be, who, either through indifference or perverseness, neglect to observe these precautionary means, we desire to call their attention to an opinion pronounced against such criminality by the editor of the *Medico-Chirurgical Review*, published more than one-third of a century ago, and which is equally as applicable to that class now, as it was to those for whom it was then intended. It is as follows:

"So overwhelming is the testimony in favor of the contagious nature of puerperal fever, and so frightful have been the consequences which have frequently resulted from neglecting

the cautions which this should have furnished, that we think that a medical man who persists in attending successive cases of midwifery, after a well marked instance of the disease has appeared in his practice, should be made amenable to the criminal tribunals of his country. A woman has confided her life to his skill and honor, and he approaches her person, the bearer of what he knows to be reputed by some of the wisest of his profession a deadly poison, the escape from which she will owe more to her own idiosyncrasy than to his humanity."

LAFAYETTE, IND.

IODINE AS A REMEDY FOR INTERMITTENT FEVER.

BY G. W. H. KEMPER, M. D.

My attention was first directed to this remedy nine years ago in an article by Dr. Parvin, then editor of the *Western Journal of Medicine*, calling attention to a paper published in the *Archives Générales*, by Dr. Willebrand, Professor of Clinical Medicine in the University of Helsingfors.* It is stated in that article that Dr. W. had treated successfully with iodine nineteen cases of intermittent fever. "Most of them yielded after the second attack, this second paroxysm being generally much milder. There were only two cases in which the disease was not conquered before the fourth. From the spring of 1868 to the following autumn, not a single case of paludal fever was treated with quinia."

In the article referred to, Dr. Parvin says:—"The employment of iodine in intermittent is not a new thing. Upon referring to Bouchardat, *Manuel de Matière Médicale de Thérapeutique et de Pharmacie*, tome second, page 647, we find, according to the formula of Barillean, the tincture of iodine, ten drops, in infusion of chamomile, three times a day—con-

Western Journal of Medicine, Vol. IV, p. 512.

tinued several days, as given in intermittent fevers; while that of Barbas is iodine in the same quantity, but administered in infusion of chickory. Nevertheless, it may be better, as advised by the Finland professor, to give the remedy in aqueous solution, in smaller doses, and with briefer intervals."

Professor Willebrand's formula is as follows:—One gram of iodine and two grams of iodide of potassium, dissolved in ten grams of distilled water; five drops of this solution in water every two hours each day.

During the autumn of 1869 I prescribed iodine according to the formula of Dr. W., with excellent results, but reading afterwards a number of conflicting statements about the efficacy of the remedy, I finally discontinued it.

Quite recently attention has again been called to this remedy. Dr. Nowodnitschanski, a Russian physician, has claimed favorable results from using ten or twelve drops of the tincture of iodine at intervals of eight hours. Acting upon this statement, Dr. Fordyce Grinnell, Physician to Wichita Agency, Indian Territory, gave the remedy a trial, and reported as follows:—"Malarial diseases were prevailing extensively. I was using quinia at the rate of one ounce per day, and my stock was almost exhausted. I began by giving ten drops of the tincture in a half glass of sweetened water three times daily to adults, proportional doses being given to children. I have been astonished and delighted with the results. I have thus treated in all one hundred and thirty-five cases of intermittent fever, seventy-four being males and sixty-one females. These have included children, and in some instances infants in arms. The quotidian and tertian types of the fever were the forms principally presented. I have also treated four cases of diarrhea (malarial), and eight cases of neuralgia (malarial), using the same remedy—only adding astringents or opiates in cases of diarrhea, and narcotics in the neuralgia cases. One hundred and forty-seven cases have thus far been treated with the iodine, and the results have been fully equal to those treated with the sulphate of quinia."*

* Cincinnati Lancet and Clinic, August 31, 1878, p. 145.

From these strong statements I have been led to make further trials with iodine, using the formula of Prof. Willebrand; or in apothecaries' weight as follows:

R Iodine, grs. xv
Iod. potass., ℥ jss
Aqua, f 3 ijss. M.

Sig. Five drops largely diluted with water every two hours. This I continue until the paroxysms are arrested, when I direct longer intervals between doses. Recently I have treated thus fifteen patients. In a majority of the cases no paroxysm occurred after beginning with the treatment. I directed these patients to report to me, and as yet no failure has been reported. It is to be hoped that medical men will give the remedy a more extended trial, and report successes and failures. The price is another item of no small matter to physicians compelled to furnish medicines in these days, when the preparations of the bark command such high prices.

MUNCIE, IND.

CASE OF POISONING BY OIL OF BITTER ALMONDS.

BY S. V. WRIGHT, M. D.

On September 14, 1878, I prescribed an emulsion of oil for Mr. H., a man in good flesh, and of extraordinary vitality, but who had been suffering with phthisis for the past six months, the apex of the left lung being affected. One-third of the oil emulsion should have been almond-water. By an error of a druggist, four ounces of oil of bitter almonds, instead of four ounces of almond-water, were used in forming the emulsion of twelve ounces. The next day, between 10 and 11 o'clock, Mr. H. took a large tablespoonful of this mixture, having previously taken in the morning a tablespoonful

of a cough syrup, containing one drachm of acid. hydrocyan. dil. to eight ounces of menstruum. Soon after taking a dose of the emulsion he felt sick, and took another spoonful of the cough mixture. At 12 M. he felt badly, and went to bed, thinking he was going to have a chill.

I was summoned in haste at 4 P. M. I met Dr. H. at the gate, who said the patient was in a bad condition as the result of my medicine, and that he had given him morphia and bismuth, and ordered milk. I found the patient almost pulseless, extremities cold, lips black, with face intensely cyanosed, looking like a corpse that had lain for hours in the sun. He gasped for breath like a fish out of water, and his speech was unintelligible. I gave him brandy, letting it run from a spoon down his throat, and kept an almost constant stream of cold water pouring on his head. After half an hour his circulation was much improved, and he complained of nausea and vomited what he had eaten the previous day, the result of having been freely dosed with mustard before my arrival. I continued the cold effusions and stimulants till 6.30 P. M.

At 7 P. M. his lips were still livid, but the pulse was good, and the face rapidly regaining its natural appearance. Twelve hours after I found him sitting up, complaining only of numbness of the extremities and weakness.

The principal subjective symptom in this case was intense pain in the head. As he recovered, he continued exclaiming, in a jerking, hesitating way, "What's—the mat-matter with me?" I judge, from the size of the spoon, that nearly or quite two drachms of the oil were taken.

GREENSBURG, IND.

Reviews.

A New Rotating Urethrotome. By JOHN A. PRITCHETT, M. D., Hayneville, Ala. New York Medical Journal, July, 1878.

This is a brief paper, published in the New York Medical Journal for July, 1878, and circulated in pamphlet form, offering to the professional public an instrument for treating contractions of the male urethra, for which such unusual merits are claimed that I feel constrained to make some few remarks in regard to it. For the benefit of those who have not read the *brochure*, I will give the author's description of the urethrotome, which is as follows:

"First, we have a plain cylindrical rod or staff, fifteen inches long, two millimeters in diameter, and with the short curve of Bumstead. The external extremity has attached on its under surface a ring to serve as a handle, while the internal extremity terminates in a screw for the attachment of filiforms. A tunneled screw-head (Gouley's attachment*) is also provided to screw on for using the finest whalebone guides. Next, and in this consists the peculiarity of the instrument, we have three tubes, each seven inches long, and fitting the rod closely, and with a slit down its entire length, so as to pass the ring-handle of the staff. At the external extremity of each tube are attached laterally two rings for handles, while each internal extremity is beveled so as to pass strictures more readily. One tube carries at its internal extremity, attached superiorly, a triangular, probe-pointed blade, nine millimeters in size; a second tube carries a similar blade seven millimeters in size, also attached superiorly; while the third tube carries *two similar blades*, each four millimeters in size, attached laterally."

In introducing the instrument, Dr. Pritchett begins by comparing it with the urethrotomes of Maisonneuve and Otis, claiming that it has combined the small size of the one with

* More properly Van Buren's.—(Reviewer's note.)

the cutting capacity of the other; and remarks that Otis's instrument is "peculiarly fitted" for operating upon contractions of large caliber, that of M. Maisonneuve being "best adapted" for the division of very close strictures. If I am not much mistaken, it was never proposed to use Otis's instrument for other than coarctations of large size; and I think he expressly states that when strictures of small caliber exist, they should be sufficiently opened, either by dilatation or division by some other instrument, to admit the dilating urethrotome; when it is to be introduced, expanded until it reaches the capacity of the individual urethra, and the contraction thus thoroughly divided. Here is most certainly a preparatory operation to prepare the stricture for the use of Otis's instrument. The special merits of Otis's instrument is its power of dividing the stricture "on the stretch," thus cutting through the entire thickness of the same.

As to the urethrotome of M. Maisonneuve, I can only say it is too well known to all surgeons that it is impossible to divide with it a coarctation greater than the thickness of its largest blade, to deserve any further comment.

Dr. P. finds, as an objection to the Maisonneuve, "that it does not give sufficient room," even after employing the largest blade, only "nicking the stricture at one point of its circumference," and allowing but the passage of a "number nine or ten English" sound. Now, by reference to the description of his instrument, as above quoted, it will be seen that Dr. P.'s largest blade is only nine millimeters thick, which corresponds exactly with the large blade of a Maisonneuve, which is also but nine millimeters in depth. Certainly he is unable to cut any deeper with his nine millimeter blade than can be accomplished with the nine millimeter blade of Maisonneuve. If the largest blade of Maisonneuve *merely nicks* the stricture, how is it possible for his, which is the same width, to do more than *nick* the stricture also?

In reference to its being only possible to "pass a number nine or ten English" sound, after division with the largest blade of Maisonneuve, I can but say, as any surgeon who

has had much urethral practice will attest, that I have often seen a number thirty French—about equal to an eighteen of the English scale—literally drop into the bladder after a tight annular stricture had been incised with the nine millimeter blade of Maisonneuve; and it is most usually of little trouble to introduce much larger numbers than “nine or ten English” immediately after such an operation.

But the great advantage of the instrument, and in which its “peculiarity” consists, is the power of rotating the blades, which, being placed on tubes, are passed over the rod or staff. This rotation allows the stricture to be cut in one direction on the passage of the instrument from before backwards, and after passing the contraction the mere turning of the ring-handle revolves the blade, and cuts it in an opposite direction on its withdrawal.

Let us analyze this peculiar merit of the instrument, and compare it on the same point with the Maisonneuve. For example:—suppose a stricture of the annular variety, the one of all others best adapted to the use of Dr. P.’s instrument, contracted to the size of twelve millimeters. His instrument with the largest blade—nine millimeters—is introduced, and the stricture divided on the roof of the urethra; the blade is rotated, withdrawn, and the coarctation thus incised inferiorly. Now, the stricture was twelve millimeters in thickness—and supposed to be the same in its whole circumference—but the blade is only nine millimeters in width; hence the cut can be but nine millimeters deep, and this subtracted from the thickness of the stricture (twelve millimeters) leaves a depth of undivided retractile tissue of three millimeters. The two incisions not being in the same direction—one on the upper surface, the other below—necessarily they do not cut the whole depth of the stricture, but divide it only nine millimeters in either direction, leaving, as above stated, three millimeters of undivided stricture tissue at the point where each incision ceases. The number of incisions increase, of course, the permeability of the strictured portion, but do not, by any means, render the incisions any deeper; and the result is that

the coarctation is not completely divided, as is done with the dilating urethrotome.

But all strictures are not annular in form. Again, suppose we have an urethra with a contraction on its upper surface; the largest blade of the "rotating urethrotome" is slid down the staff, and the stricture incised at this point. The stricture is now cut; what, then, is the need of rotation?—What is the necessity of revolving the blade and incising the floor of the canal, which is perfectly healthy? True, such a procedure would give more "room," but it is unsurgical; and the very point for which urethrotomists are contending is to cut the strictured part *alone*, and avoid all damage to the sound tissue. The same reasoning applies to the double-bladed tube.

This advantage, however, of giving "room" for the introduction of a sound by the multiple incision over Maisonneuve, is not quite so apparent as might at first appear. The same can be accomplished by the bilateral blade of Maisonneuve, which also cuts two sides at once. And, again, should we wish to incise the floor of the stricture after dividing its roof with the single blade, we have but to substitute the staff grooved on its convex side, and the same blade will cut it here also. A *real* disadvantage in rotating the blade in the ampulla behind the coarctation, is the danger of lacerating the healthy urethra, as the canal is always collapsed; and hence it would be very easy for the mucous membrane to become entangled in the blade or blades.

Dr. P. remarks that he is as yet unable to assert whether the "rotating urethrotome" will effect a radical cure of urethral stricture; but says his own results with it are "as good as any ever obtained from Otis's instrument." Here I would ask if he has followed his cases up for any length of time after such an operation? Many still doubt the ability of the Otis instrument of effecting a permanent cure; and if there is any doubt of curing the stricture after being cut when "on the stretch," how can the rotating instrument ever accomplish it, when in many instances the stricture will be found much

thicker than the thickness of his largest blade? We would like to see Dr. P.'s statistics of cases, which, to be of much value, should extend up into the dozens.

Dr. P. says, with great truth, that his instrument "may be called a modification of Maisonneuve," for we are unable to see any material difference between the two, except that the one has a blade attached to a tube which slides *over* the staff, the other has a blade at the end of a blade-rod which glides in a groove *in* the staff. Cutting in opposite directions can be as well accomplished by substituting the convex or concave-grooved staff of a Maisonneuve, as required, as by revolving his blades; and Maisonneuve's bilateral blade will divide both sides of a coarctation as well as his double-bladed tube.

Still again: the armamentarium of urethral instruments has already attained such dimensions, that unless an instrument presents some really valuable point, it is more than useless, and only serves to confound the early student and lumber the shelves of the more advanced operator.

In conclusion, I may safely say, with all due deference to Dr. P.'s skill and mechanical ingenuity, that the "rotating urethrotome" will never supersede the urethrotome of M. Maisonneuve, nor the dilating instrument of Dr. Otis.

W. M. M.

Annual Reports of the Supervising Surgeon-General of the Marine Hospital Service of the United States, for the Fiscal Years 1876 and 1877. By JOHN M. WOODWORTH, M. D. Washington: Government Printing Office. 1878.

It appears that the report of the Supervising Surgeon-General for 1876 was not printed, so the present volume of two hundred and thirteen pages contains the reports of the operations of the service for 1876, as well as that for 1877. This is the report of the service for the sixth year of Supervising Surgeon-General Woodworth, and makes a creditable showing for his management of the wide-spread and complicated

duties devolving on him. The number of seamen treated in 1870, at seventy-four places, was 10,560, at a cost of \$38.41 per capita; the number in 1877, at one hundred places, was 15,175, at a cost per capita of \$24.22—a reduction of over forty per cent.

The book is full of instructive statistical tables. One of these gives relative frequency of death from the various diseases that were fatal, consumption taking the lead at 20.27 per cent. of the whole, being very nearly the general average in civil life; remittent fever comes next, with 10.12 per cent.; and pneumonia third, with 7.60 per cent. These are not the percentages a civilian, *a priori*, would have guessed.

Beside the subjects presented by the chief, there are appended reports from subordinates, full of interest and instruction, viz., recommending the adoption of the metric system of weights and measures in the service, by Oscar Oldberg, Ph. D.; Physical Examination of Seamen, by Surgeon P. H. Bailhache; River Exposure and its Effects on the Lungs, by Surgeon Walter Wyman; and Yellow Fever at Savannah and Brunswick in 1876, by Assistant Surgeons George H. Stone and Henry Smith, and at Fernandina in 1877 by Surgeon Robert D. Murray.

J. F. H.

On the Therapeutic Forces—An effort to consider the Action of Medicines in the light of the modern doctrine of the Conservation of Force. By THOMAS J. MAYS, M. D., Member of the Luzerne County Medical Society, Member of the Pennsylvania Medical Society, etc. Philadelphia: Lindsay and Blakiston. 1878. 143 pp.

The fundamental idea of this little book is that all remedial agents must have their operations scientifically explained—a very good fundament if its advocate does not strain things too hard to accomplish his purpose.

Dr. Mays divides medicines into chemical stimulants, mechanical stimulants, and narcotics. A chemical stimulant is

one that harmonizes with vital action, exciting increased molecular activity by giving up its force to accelerate force already acting: cod-liver oil is an example. A mechanical stimulant is one that antagonizes vital force and increases molecular activity, by its liberated force opposing the vital force of a pathological character, and subduing it: quinia is an example. Narcotics are drugs whose forces, being liberated, overpower the molecular activity of the nerves, whether normal or abnormal. Alcohol in large doses is a narcotic, though in small doses a chemical stimulant; opium in large doses is a narcotic, though in small doses a mechanical stimulant.

This is a comprehensive plan, but it will not capture the clinician, because he will administer quinia without regard to whether it cures intermittents by running with the grain, or against the grain, of vital molecular activity. Nor will it satisfy the pure scientist, because its premises are neither axioms nor demonstrated propositions, and its deductions are illogical and forced.

The book seems to be the work of one of that large class of good men, and not bad doctors, who mistake assumptions for facts, reason badly, think tremendously, and write fluently; and it must look to that same large class for readers and admirers.

J. F. H.

Pocket Therapeutics and Dose-Book—With Classification and Explanation of the Action of Medicines, Poisons and their Antidotes, etc. By MOSES STEWART, JR., M. D. Price, 50 cents. Detroit, Mich.: Emil Schober, Printer. 1878.

In one hundred pages, the pages being somewhat less than four inches by three, we have the practice of medicine given. Surely this is an ambitious design—ambitious enough, indeed, but impossible of attainment. We can not see why a physician of Dr. Stewart's ability attempted it; and for his own reputation and for the good of the profession, the sooner he

has the book suppressed the better. The book is a blunder, and it is full of blunders; and the only possible apology for the volume is similar to that which "Susan" offered in "Midshipman Easy," for having a baby without having a husband, "It is only a very little baby."

Proofs of the blunders are abundant, and some will be presented. The first page of printed matter is headed "errata," and fifteen errors noted and corrected. The conclusion, therefore, would be that this list is complete. Yet on page 7, we read "alements" and "non-nitrogenous;" and on the next "chalybeats," whatever these words may mean. On page 11, we have the following: "*Order 1.—Inebriates*—are very like stimulants; given in small doses they are exhilarants, but in large doses they depress the heart's action, and impair the intellectual functions." Now if the first part read "*Inebriates* like stimulants," we could understand the meaning at once. But when we read of these inebriates being given in small or in large doses, we are simply shocked at the fearful cannibalism. This out-Herods Herod, out-Hammonds Hammond—the former only made way with a few hundred babies, and the latter asks only for the homicidal maniacs a short shrift and a sure cord. But now dipsomaniacs, male and female, of all sorts, conditions and ages, are to be sacrificed upon the altar of Æsculapius—butchered not to make a Roman holiday, but to cure disease. We have not the heart to even ask what the Detroit dose of inebriates is, and whether the supply equals the demand for this new article of the *materia medica*. During the height of the present yellow fever epidemic, the telegraph announced that a Detroit firm of druggists—only wicked people would suggest this was simply a free advertising dodge—with an eye single to human good or to their own gain, had a remedy for yellow fever, and that this philanthropic firm was sending some of the wonderful medicine to the stricken cities of the south. Was that extraordinary remedy inebriates?

But let us pass from this melancholy subject. We read of "ipecacuanhæ" (in the nominative), of "podophyllii," "pro-

plylactic," "anthelmintic," "lini ferina," "venereal," "taraxicum," etc.

We learn, on page 36, that ergot is to be given in labor only in the third stage, and that it arrests "post partum hemorrhage." As the third stage of labor is the expulsion of the placenta, ergot would have little obstetric use. Nevertheless we are glad to know it is good in post partum hemorrhage.

Under the head of "convulsions," we are advised to use bromide of potassium in all forms,—this wonderfully simplifies the treatment of the disorder; under that of "abscesses," we find that "poultices check formation of pus, assist maturation,"—a delightful duplicity of action. We have a variety of cephalalgia called "neuralgia"—[we wonder if this headache *neuralgia* can ever be caused by cogniac, and cured by ammoniac?]^{*}—of a pain that is "nitting," of a "uterine lachial* discharge," of "dysentery," etc.

Now, if this be not a book of blunders, where can blunders be found?

Traité Elementaire de Chirurgie Gynecologique. Par LE DOCTEUR A. LE BLOND. Paris, 1878.

Dr. Le Blond, the author of this elementary treatise upon gynecological surgery, is well known to the profession as the able editor of the *Annales de Gynécologie*. He is also well known for his translation into French of the late Dr. Fleetwood Churchill's able volume upon diseases of women.

The volume which he now introduces to the profession contains between six hundred and seven hundred pages, two hundred and eighty-one illustrations, a very full description of instruments required in gynecological surgery and of the operations themselves. Very many of these illustrations are

^{*} That uterine lachial discharge is possibly something as bad as post partum hemorrhage. Of course lachial is not a misprint, lochial being meant, for then it would be unnecessary to qualify it as uterine, since a lochial discharge only comes from the uterus.

of American instruments. Dr. Le Blond, who is usually remarkably correct in his text and woodcuts—rarely making a mistake of any sort—we think has fallen into some. For example, when Dr. Albert H. Smith looks, on p. 280, at the illustration of the pessary there given his name, he will hardly recognize the instrument; and then when Dr. Sims finds, on p. 297, an instrument marked as the *Redresseur de Simpson*, he will be somewhat surprised that so able and learned a French physician should not know that the representation was of Dr. Sims's, not of Dr. Simpson's, instrument. These, however, are trifling errors in Dr. L.'s excellent book.

But there is a graver mistake made, and it is in the history of abdominal ovariectomy. Laumonier is credited with having, in 1781, successfully extirpated the ovary in a case of encysted dropsy of the tube complicated with ovaritis. Then several American operators are stated to have performed ovariectomy several times successfully, and the names mentioned are Nathan Smith, Atlee, Peaslee, Kimball and Dunlap. Not a word of the Father of Ovariectomy, McDowell. Surely this is the play of Hamlet with Hamlet left out!

Nevertheless the volume is a good one, and we wish some enterprising American publisher would have it translated and issued in this country.

Visions: A Study of False Sight (Pseudopia). By EDWARD H. CLARKE, M. D. With an Introduction and Memorial Sketch, by OLIVER WENDELL HOLMES, M. D. Boston: Houghton, Osgood and Company. 1878.

Dr. Clarke, eminent as a physician, as a teacher, and as a writer, became the last years of his life the victim of a protracted, fatal and most painful disease, cancer of the rectum. For three years, we believe, he was looking death in the face, traveling, indeed, in great physical agony right to it. This book was written in those years, partly as a diversion from his painful condition, and "in hours of distress which were inter-

vals of agony." Not only so, but in the midst of his suffering his devoted wife, then most needed by him in all his years, was taken sick, and died after a brief illness. Thus this book is the product of one who was drinking no common draughts of sorrow and of suffering. To the memory of his wife who, as he states, inspired him with courage to undertake the preparation of the work, and who by her pen rendered its preparation possible; and to his daughter who, taking the pen snatched by death from her mother, continued her mother's inspiration, and assumed her mother's task, the book is dedicated.

The introduction and memorial sketch are full of affection, of just appreciation, of tender grace, and written at once with the strength and beauty which so mark the gifted author's utterances.

The book itself is intensely interesting and instructive. It is chiefly a physiological study, and explains most visions as dependent upon automatism; they belong to the individual, to his physical nature and condition, and are not external to him. Nevertheless, after thus disposing of the greater part of these visions—making them pseudopia, false sight—there is a residuum not thus to be disposed of. In referring to the visions of the dying he remarks:—"Probably all such visions as these are automatic. But yet who, believing in God and personal immortality, as the writer rejoices in doing, will dare to say *absolutely all?*—will dare to assert there is no *possible* exception?"

In Carlyle's life of John Sterling, there is a chapter devoted to Coleridge, in which the following passage occurs:—"A sublime man; who, alone in those dark days, had saved his crown of spiritual manhood; escaping from the black materialism, and revolutionary deluges, with 'God, Freedom, Immortality,' still his: a king of men."

Let us be thankful that such a man as Edward H. Clarke has lived, and that in the searching ordeal of things material, he found no resting-place in materialism, but saved his crown of spiritual manhood, with God, Freedom, Immortality still his.

A Practical Treatise on the Medical and Surgical Uses of Electricity, including Localized and General Faradization, Localized and Central Galvanization, Electrolysis and Galvano-Cautery. By GEO. M. BEARD, A. M., M. D., and A. D. ROCKWELL, A. M., M. D. Second edition, revised, enlarged, and mostly re-written. With nearly two hundred illustrations. New York: William Wood and Co. 1878.

Doctors Beard and Rockwell are so well known to the profession, not only of this country but of the world, as diligent and faithful workers in the department of electricity, in its medical and surgical applications, that whatever they utter demands respectful attention,—they speak with authority. When the first edition of their work, in 1871, was so soon exhausted, sufficient evidence of the need of such a book, and of its full appreciation by the profession, was given.

It is unnecessary to state that the second edition is still more valuable, and deserves a place in the library of every physician.

Anatomy, Descriptive and Surgical. By HENRY GRAY, F. R. S., Fellow of the Royal College of Surgeons and Lecturer on Anatomy at St. George's Hospital Medical School. With five hundred and twenty-two Engravings on Wood. With an Introduction on General Anatomy and Development. By T. HOLMES, M. A., Cantab., Surgeon to St. George's Hospital, etc. A new American, from the Eighth and enlarged English edition. To which is added Landmarks, Medical and Surgical. By LUTHER HOLDEN, F. R. C. S. Philadelphia: Henry C. Lea. 1878.

The American edition of Gray's Anatomy has been supervised by Dr. Richard J. Dunglison, and the publisher has greatly added to the value of the volume by appending Mr. Holden's Landmarks.

We need not say a word in commendation of this great work. It is the text-book on anatomy; there is no attempt even to equal, still less to rival it, and can not be for many a day.

FOREIGN CORRESPONDENCE.*

DR. YANDELL'S LETTERS FROM ABROAD—No. VI.

LONDON, July 20, 1878.

Bichloride of methylene is a far safer anesthetic than chloroform. In nearly nine hundred operations, he has "never once been in the smallest anxiety about a patient." He uses Dr. Junker's apparatus. The nurses have the sponges ready of a certain size. "If they be too small, they may be lost; if they be too large, they can not be introduced." Only two assistants are required. One assists in tying vessels, and in preventing the intestines coming out after the cyst has left the abdominal cavity. As to the instruments required, the first is a scalpel—the point to be used mainly. If a vessel is cut it should be caught by forceps, so that no blood drops into the abdominal cavity. The peritoneum is then divided, avoiding the cyst. "One or two flat touches of the scalpel on the peritoneum are sufficient to divide it." A broad director is passed into the opening, and the peritoneum is divided by a blunt-pointed knife; a sharp-pointed knife may wound the intestines, or even the bladder if high up. Having incised the peritoneum for four or five inches, it becomes necessary to empty the cyst; and this is done by a trocar, "which is furnished with outer spring-hooks to fasten the cyst." It is passed into the cyst, the point withdrawn, and the fluid escapes by the tube attached to it. "As that is done, the outer hooks are opened, the cyst is caught hold of and easily fastened to the canula, and pulled out through the opening in the abdominal wall; the fluid passes out, the cyst is held by these grasping claws, and, if the cyst be free, it of course readily and easily follows the instrument."

At this point comes the question of dealing with the adhesions, either to the abdominal walls or to the omentum, or to the intestines, or to some of the structures in the pelvis.

* This abstract of Prof. Wells's Lectures on Ovariectomy is continued from September No., p. 182.

Sometimes the incision finds the cyst glued to the abdominal walls. If the adhesions be very close, it is well to empty the cyst before separating it from the belly wall. Often the cyst may be grasped by its interior surface, and so drawn out and the adhesions torn. Occasionally some firm band must be severed by the knife or scissors; but this is rarely the case, and can almost always be done without dissection. Then after clearing the adhesions, the tumor may have to be broken up, or other cysts tapped, before it can be removed. The incision may, after all, have to be enlarged. After the withdrawal of the tumor the pedicle comes into view; it may be a band of greater or less breadth, or a cord or root, short or long, or it may be divided into several portions. There are various ways of dealing with the pedicle. In the earliest operations it was tied with whip-cord, and the ends were brought out through the wound. Then leather ligatures were used, the ends cut short off, and the pedicle dropped back into the abdomen. Then came the clamp. There is much to be attended to in the application of the clamp. Mr. Wells generally gives the last turn of the screw with a pair of forceps, instead of trusting to his fingers alone. When one part of the pedicle is much thinner than other parts, he prefers to put a ligature round the pedicle below the clamp. If the ligature be put on before the clamp is screwed up finally, it makes the pedicle round, so that the clamp is less likely to slip. The clamp, being curved, does not press upon the edges of the wound. It keeps any dead or dying piece of pedicle outside the abdominal wall; and as to the part of the pedicle outside, a little perchloride or persulphate of iron sprinkled on it, converts what might otherwise become putrid into a piece of hard leather, "which can not do any possible harm." If the pedicle be too short or too broad for the clamp, then it becomes necessary to use the ligature. It is dangerous to use sharp-pointed instruments near the abdominal cavity, as intestines or veins may be wounded. So the needle has a blunt point; and to avoid entanglement of the silk it has a double eye. It is not difficult to push such a needle even through the thick

part of the cyst; and when the instrument is withdrawn, two threads are ready to be tied. He first makes a "surgeon's knot," and then an additional knot, believing there is greater safety in the surgeon's knot with a third knot, than in any reef knot. With the third knot, and the pedicle tied in two or more parts, it is secure; but sometimes the pedicle will split at the spot where the needle was passed. "If so, all that is necessary is to take another turn of the silk and just bring it round from one side to the other, so that the whole pedicle is compressed." But if this last can be dispensed with it is well, as it crumples up the pedicle, and "makes a tight band across the pelvis."

A third method is to use the cautery; but before proceeding with its discussion, Mr. Wells said, suppose we have got so far as the removal of the tumor, the application of the clamp or ligature, and cut the tumor away, then it becomes necessary to cleanse the peritoneum from blood or ovarian fluid, which is done by means of sponges. This should be done thoroughly, as the peritoneum bears it well; "the more careful this sponging, the better is the result to the patient." The number of sponges is a matter of moment; they ought to be carefully counted. There are cases where a sponge has been found in a patient's abdomen after her death. Once such a mistake occurred to himself. He was just finishing, when a gentleman said a sponge was left in. He asked the nurse if all the sponges were there; she answered, "they are all here—I have sixteen." The cavity was explored for a sponge, and none was found. The wound was sewed up. Late in the evening word came a sponge was missing—a sponge the nurse "knew." The patient seemed pretty well. Next morning she was worse. Two stitches were taken out and the finger inserted, and there was the sponge; the movements of the intestine had brought it to the wound. The patient did well. Another time a sponge was missing, the abdomen was carefully explored, but no sponge was found. The nurse was positive; so another hunt was made for it, and it was found at the back of the liver, betwixt the liver and

the diaphragm. It was a small sponge, and since then Mr. Wells objects to too small sponges.

Then as to the cautery; it was invented to apply to adhesions and to adhering omentum, which were clamped first and then cauterized. Apparently Mr. Wells has abandoned the cautery as a primary means of treating the pedicle. When the cautery is indicated, he prefers Paquelin's thermo-cautery. It is a hollow platinum cone, heated first and then kept hot by a stream of benzoline vapor. He also uses a lamp by Collins for throwing light upon a dark spot, where a bleeding vessel may lurk.

After the thorough cleansing of the peritoneum comes the closing of the wound. Once he used two harelip pins, and put a twisted suture round them. Now he uses silk exclusively. He has the needles threaded in pairs, two needles to each piece of silk, and puts them into a piece of carbolized gauze. Then he uses Mr. Wormald's needle-holder. "Each needle is passed from within outward;" by so doing, there is no risk of wounding the intestine. First, one of the needles to each piece of silk, then the other; when passed the assistant holds the ends of the sutures up, while the next needle is passed in. A flat sponge is placed within the wound while the sutures are being passed, to catch any drop of blood; when all the stitches are passed this sponge is withdrawn, and the assistant grasps the abdominal wall tightly while the sutures are tied. This keeps out intestine or omentum. There are cases where fatal obstruction of the bowels was caused by the intestine being caught in a suture. If the omentum be caught, it leads to troublesome vomiting. The surgeon should then occasionally pass his finger inward, during the tying of the sutures, to make sure that there is nothing intervening in the wound.

As to dressing the wound, it is kept as dry as possible. The last and best thing is gauze saturated with thymol, the most recent substitute for carbolic acid. Thymol and spermaceti are mixed together, and the gauze charged with it and simply put over the wound. Eight or ten other folds are put

over the first, after which strips of plaster are applied and then the flannel bandage. This last should be lined with linen or calico to lessen the irritation. The bandage is tightly fastened over the gauze with safety-pins. "That being done, the patient is carried to bed, left there quiet and comfortably warm, with only the nurse in the room."

As to the after-history of the wound: Where the clamp is used the pedicle is found attached to the abdominal wall, but the uterus has free movement. In stitching up the wound the stitches should go through the peritoneum, so that no oozing can get through. "If the two peritoneal surfaces be held together, they unite quite firmly and accurately." Mr. Wells is very earnest about the propriety and necessity, in all cases of wounds of the abdominal wall, of bringing the two peritoneal edges accurately and closely together.

Mr. Wells never uses wire ligatures to the pedicle. The clamp has advantages at the time of operation; it is put on quickly and the bleeding is suppressed with complete security. He has never known dangerous bleeding from the slipping of a clamp, whereas it has been known to occur with the ligature. For security from primary hemorrhage the clamp has the advantage. The advantage of the ligature is that it allows the wound to heal with less interference from less frequent dressing, and the patient is so far more comfortable. The clamp often causes no inconvenience, the patient not being aware of its being there; but at other times there is redness and swelling, with some discharge. As to the results obtained, "the mortality of the same operation in the hands of the same operator is eighteen per cent. more with the ligature than the clamp." This outweighs any questions of a few more days in bed, or some trouble in dressing the wound. No surgeon should bind himself to the extraperitoneal or intraperitoneal treatment of the pedicle, but should carry out the method best adapted to the case before him. "If the pedicle be small enough to be securely held in a clamp of moderate size, and long enough to permit the clamp being fixed outside the closed wound, without much pull on the

uterus or broad ligament, no more ready or more successful method than the clamp can be desired. When the pedicle is so short, broad, or thick, that a very large clamp would be necessary to secure it, that the wound could not be closed around it, and the traction upon the uterus excessive, either the ligament or the cautery should be preferred to the clamp. Or if, after applying a clamp, it be found that it can not be fixed outside without undue strain upon the uterus, either the cautery may be used, or the pedicle may be transfixed and tied, and the clamp removed after it has served its temporary purpose." The use of the antiseptic treatment may cause the other methods to be preferred to the clamp. The cyst may be twisted off by Macleod's plan. As to adhesions, if they be torn off, the abdominal wall contracts and stops the bleeding; if cut by knife or scissors, the bleeding is often troublesome. Compression by torsion-forceps will usually stop the bleeding, or a ligature may be required. In the only two cases where he had trouble with bleeding, the abdominal walls were slack, and he held the two loose folds firmly together while the sutures were being put in, and passed a couple of needles through the whole thickness of the abdominal walls.

As to accidents which may happen: A sponge has been left in the abdomen, as has been seen. Once, too, several pairs of torsion-forceps had been used, and a pair were found missing on counting them. This discovery was made two hours after the operation. The patient was examined, but all seemed well; she had a bad night, however; so on the pretext of changing the dressings methylene was given, the wound opened, and then the forceps were found "wrapped up in the omentum." The patient got quite well. He comments thus: "Pray let me use this confession to impress upon you the necessity not only of counting sponges, but of counting instruments also, that you may avoid any such painful experience." If it be necessary to employ drainage, a glass tube, with a shoulder to prevent its slipping into the abdomen, is passed in at the lower angle of the wound, and two stitches are put round the shoulder; through this tube an elastic catheter or a

piece of rubber-tubing may be passed, and a sponge may be saturated with some antiseptic and placed over the tube.

As to the after-treatment of ovariectomy, he alluded first to warmth and diet and amount of alcohol. Once hot steam and the free use of opium were thought essential. Now a room of comfortable temperature, and no more opium than is strictly indicated, are preferred. As a rule, and as an article of ordinary diet, no alcohol is given—though given freely when medicinally indicated. As a means of lowering temperature, aconite, quinia, salicylic acid, have all failed. Ice to the head, by means of a cap made of coils of india-rubber tubing, connected with a pail of water with a lump of ice in it, has the effect of lowering the temperature very markedly. If the temperature is rising, the rise is checked; if it be very high it can be lowered, and so time gained for the recovery of the patient. Many of the evil results of ovariectomy seem to be due to too high a temperature. The brain gets overheated, the secretions are checked, the kidneys and bowels do not act; to lower the temperature relieves all these disturbances. Whenever bad symptoms, as a rise of temperature, pain, sickness and rapid pulse, set in, it is always well to examine the abdomen carefully, to see if there be any fluid accumulation there. It is common to find fluid in the most dependant part, commonly in Douglas's pouch. Passing a trocar by the vagina permits of the escape of fetid fluid, with great relief to the symptoms; sometimes it becomes desirable to leave in a canula to complete the cure. One of the objections to the ligature is the formation, sooner or later, of a pelvic abscess. Months even after the operation an abscess may form, and the ligature come away by it with portions of the broad ligament with it.

Of incomplete operations or exploratory incisions: Of his first five hundred ovariectomies, twenty incomplete operations and twenty-four exploratory incisions occurred, or about ten per cent.; of four hundred more recent cases there have been but thirty of both, or about seven and a half per cent. "Out of these thirty cases, death was probably accelerated in eight.

In four others, whose death occurred at various periods from fourteen to fifty-two days, the incision probably had not much effect either in lengthening or shortening life." In five patients a part of an ovarian cyst was removed, and all appear to have been completely cured. In two the remaining part of the cyst was drained. He then discussed at some length the question of incomplete operations, from their moral as well as other aspects. He then told of the results of operations, and from a circular sent out found that a number of women who were unmarried at the time of operation had married since, and many of these, as well as those who were married when operated on, had since borne children; some one, some several. "Nor was there anything in the result after removal of both ovaries which seemed remarkable, except that in three cases there was what appeared to be something like a return to normal menstruation. In most of the cases, when both ovaries were removed, there has been nothing like any return to menstruation, even in young women."

Then came the question, "What are the results of ovariectomy?" With his increasing experience, the mortality has fallen from a death-rate of 25.4 per cent. in the first five hundred cases, to seventeen per cent. in the last hundred. "Ovariectomy more certainly saves life from threatened death, restores a woman more certainly to perfect health, renders her more fit for all the requirements of daily life, than almost any other surgical operation. She can scarcely be said to be mutilated." Lord Selborne said, at the opening of the new branch of the Samaritan Hospital, as regards the results of ovariectomy:—"Instead of the four years of declining health and hopeless misery which these women would have had to anticipate, not only these four years, but twenty-five years, which upon the average had been wholly saved to them, were years of restored health, usefulness and happiness."

In his sixth lecture, Mr. Wells spoke of the second ovariectomy in the same patient for recurrent disease. Four such cases have been published by him in his work on "Diseases of the Ovaries;" and since then he has operated on seven

more, all of whom have recovered. Of ovariectomy performed during pregnancy, he has one more case to add to the nine previously published; here the operation was followed by the birth of a healthy child at full term.

Having referred to the history of the operation, changes in the mode and in the instruments, Mr. Wells went on to speak of some points in the after-history of the cases. It was soon found that the peritonitis often resulting therefrom was really septic in its nature; consequently our efforts were turned in the direction of dealing with blood-poisoning. He spoke of the arguments that had been brought forward in favor of the antiseptic treatment of wounds, of the opposition to it, and the references made to his own great success without any antiseptics. After careful study of antiseptic ovariectomy in Germany, Mr. Wells commenced this year by adopting it himself. It had already been adopted by Mr. Knowsley Thornton at the Samaritan Hospital with gratifying success. Thymol seemed the agent best adapted for ovariectomy; but in order to test it thoroughly, it was used alternately with carbolic acid. The result has been that of completed cases of ovariectomy, out of fourteen but one has died, and she died of tetanus after the healing of the wound. After the most careful and critical survey of his cases of operation antiseptically, twenty-two in all, he says:—"I shall certainly continue the trial until I arrive at some conclusion, one way or the other; and I think I have already noticed a considerable difference in the progress of cases after operation, since I used carbolic acid and thymol." The pyrexia is lessened; "in antiseptic ovariectomy fever is the exception, whereas formerly it was the rule." The facts in favor of antiseptic treatment furnished by four German surgeons are, that before this plan was adopted, sixty-five cases resulted in thirty-three deaths; since then one hundred and five cases have been followed by thirty-three deaths—a very marked alteration in the same hands. "As far as the inquiry has hitherto extended, the results would encourage us to continue the practice carefully, but without being seduced into the extravagances of some

whose faith in carbolic acid knows no bounds." Like Prof. Lister, Mr. Wells is most careful in every way in applying the system; in each case, their faith in the plan is compatible with the minutest care and scrupulous regard to cleanliness—they, indeed, neglect no precaution in their judicious zeal. "Let us regard," he says, "the antiseptic treatment not as a substitute for those measures which have already proved effectual, but as an additional safeguard." He expressed a strong opinion that further experience will prove the plan to be of real and very great value.

The last lecture was on the subject of the surgical treatment of uterine tumors. His experience comprises forty-five cases operated upon through the abdominal wall. In twenty-four the tumors were completely removed. These operations are much more dangerous than ovariectomy. Sometimes one or both ovaries may have to be removed with the tumor. A table of forty-five cases was then given. Of twenty-one cases where an exploratory incision was made, and the tumor punctured or partially removed, only two died—one a hopeless case, which died in three hours; the other lived fifteen days, death apparently not being hastened by the operation. With regard to the method of operating, the only difference consists in a longer incision and greater difficulty in securing the bleeding vessels, which require careful ligature. It is seldom the pedicle is sufficiently long to admit of extraperitoneal treatment, though this gives the best results when practicable. It is the treatment of the pedicle, "or the medium of connection between the tumor and the uterus," which leads to the greater danger of this operation as compared with ovariectomy. He then spoke of Freund's method of entirely removing a cancerous uterus, describing it by means of a diagram. He concluded his lectures by a high eulogium of McDowell, who he says is justly looked upon as the "father of ovariectomy," and who made the operation "a boon to humanity." "McDowell was wise, practical and prophetic. He carefully studied the subject which filled his mind; did with an enviable success what his opportunities permitted; and looked with

an anxious eye on the prospect opening up to his successors. We, more happy in our opportunities, have entered into full possession of what to him was little more than a promised land." Mr. Wells has attained the operative success which McDowell gave as the standard; and, more than that, his "example has emboldened others, and will be the means of still further extending to human suffering the consolatory assurance of the prospect of relief, and insuring the certainty of its realization by the many skillful hands which are now betaking themselves to the work." He sounded a warning to that class who rush in where "angels fear to tread." The simple "wish," he said, "to do well what others have done is not all that is wanted. Step by step their course must be followed. A fancied inspiration will not alone lead to success. "Listen," he added, "to the words of the great Kentuckian:"

"It is my most ardent wish that this operation may remain to the mechanical surgeon forever incomprehensible. Such have been the bane of the science, intruding themselves into the ranks of the profession with no other qualification but boldness in undertaking, ignorance of their responsibility, and indifference to the lives of their patients; proceeding according to the special dictate of some author as mechanical as themselves, they cut and tear with fearless indifference, utterly incapable of exercising any judgment of their own in cases of emergency, and sometimes without possessing the slightest knowledge of the anatomy of the parts concerned. The preposterous and injurious attempts of such pretenders can seldom fail to prove destructive to the patients and disgraceful to the science. It is by such this noble science has been degraded, in the minds of many, to the rank of an art."

McDowell strove, as Mr. Wells has expressed it, to make ovariectomy a boon to humanity, but he early foresaw the dangers of its abuse from rash and indiscriminate rivalry amongst his followers. I myself can count up quite half a hundred of women whose lives were sacrificed by medical men who undertook the operation, one of them at least as his maiden effort, and most who could be properly called mere mechanical surgeons. There, was, indeed a time in Louisville when the failures had reached such a point that

women with ovarian tumors positively refused to have them removed by surgeons here. These aspirants for surgical distinction, to whom I have alluded, turned a deaf ear to the words, and their backs to the counsels, of wisdom. It is to be hoped that other lives will not again be placed in their hands.

Mr. Wells concluded as follows:—"Allow me to read a sentence or two from one of those able reviews which make one regret that the day of the medical quarterlies is passed. (British and Foreign Med. Review, April, 1873.) 'All honor to McDowell, of Kentucky, who, to use the words of Hufeland, 'looked upon his profession as a high and holy office, who exercised it purely, not for his own advancement, not for his own honor, but for the glory of God and the good of his neighbor, and who, long since called to give an account of it, is no doubt reaping the reward of his faithful stewardship.'"

Professor John Wood, of King's College Hospital, so well known in America and so much liked in this great city, exhibited at one of the last clinics I had the opportunity of attending, a case of hernia, radically cured by dissecting away under the carbolic spray a thickened and large sac of a scrotal hernia, and removed a considerable portion of consolidated and irreducible omentum. Professor W. stated that he had performed a good many operations of this kind for the radical cure of irreducible omental hernia, and so far with uniform success. The absence of symptoms subsequent to these operations was remarkable; very little discharge and no suppuration had followed in most of them.

In one case, that of crural hernia in a woman of sixty, who was crippled from rheumatism, no truss of any kind had been or could be worn, and the patient having had a bad cough, was brought in with constipation, vomiting, and the usual symptoms of severe strangulation. The taxis under chloroform was of no avail, and an operation for the relief of the strangulation was at once performed without carbolic spray. A large mass of adherent omentum was found to overlap and

conceal a knuckle of chocolate-colored bowel, the stricture was divided, the bowel returned, and about half to three-fourths of a pound of omentum was then removed by tearing off with the fingers and forceps. Small silk ligatures were applied to a few small bleeding vessels, and then the sac was cut off close to Poupart's ligament. A thick silver wire was then carried through the neck of the sac and stump of omentum, transfixing Poupart's ligament on the one hand, and the pubic portion of fascia lata on the other, and twisted so as to bring Poupart's ligament close down to the pubic fascia lata close to the femoral sheath. The patient had no bleeding, no peritonitis whatever, and very slight discharge. She was convalescent in three weeks, and went out of the hospital with the parts well closed up and consolidated. She has not attempted to wear any truss, and has had no return of the hernia since, the operation being performed nearly nine months ago. Simple carbolic lotion was used as dressing, and a drainage-tube kept in for a fortnight.

All cases of strangulated hernia in which the bowel is not damaged, and in persons under the middle period of life, are treated by Prof. Wood in this manner, the hernial opening being closed by wire and any adherent omentum removed.

For the radical cure of inguinal hernia he had now operated in more than two hundred and fifty cases, and as far as could be ascertained the proportion of cures was seventy-five per cent., while those which had not been quite cured had had a truss made available, which had not been the case before the operation. Only three deaths had occurred—one from pyemia, one from erysipelas, and one from peritonitis, but *not* in consequence of the operation.

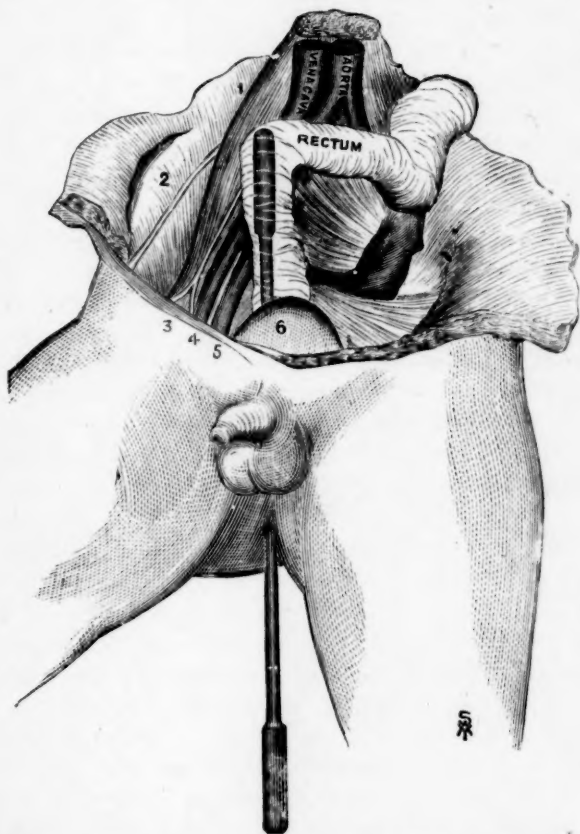
Prof. Wood next showed a case which had been operated on eighteen years ago on the previous Saturday. It was an inguinal hernia of the right side, one of the largest he had ever operated on; the patient aged thirty-five years, a brick-layer's laborer, subject to heavy lifting strains. The patient was operated on in the presence of many London surgeons,

among whom was the late Sir William Fergusson. He wore a truss for nine months, and then discarded it, continuing his laborious occupation. He had been shown from time to time at the Medico-Chirurgical and Pathological Societies, as well as in the theater of King's College Hospital. Latterly he had had a bad bronchitis, which had produced a weakness and bulging on the *opposite* or left groin, for which he had applied to Professor Wood. In other cases he had operated on sixteen, fourteen, twelve, eleven and ten years ago, and whom he had been fortunate enough to inspect and show to the class from time to time, proving the *duration* of the cure from operation in these cases, upon which doubt had been thrown by some surgeons.

Professor Wood believes that the proper performance of his operation will yield, in selected cases (in which the valvular action of the walls of the inguinal canal can be restored), as large a proportion of successful cases, with as little risk to life, as in most other surgical operations.

You possibly saw, during last spring, that M. Verneuil had read a paper before the French Academy of Medicine on amputation of the hip-joint, and advised that the blood contained in the limbs should be driven back into the trunk by means of Esmarch's bandage, the flaps be made from the sides, and the vessels ligatured before division. The paper was based upon a single successful case, in which it is claimed that the operation was almost bloodless. I think he will find few surgeons in America who will follow his teachings, so far at least as relates to the flaps and ligating the vessels before cutting them. Then with Lister's abdominal tourniquet—an invention, however, which really belongs to the elder Pancoast; or with a compress made of folded towels, or a pincushion laid on the vessel, and kept in place by a stout rubber band encircling the abdomen (as practiced by Spence in his last operation, in which but two ounces of blood were said to have been lost;) and, finally, by a method recently devised by Mr. Richard Davy for compressing the internal iliac artery,

through the rectum on the pelvic wall, a figure of which I here give. There would seem to be no other means for restraining hemorrhage desired.



(The rectum is supposed to be transparent.) 1.—Psoas magnus muscle.
2.—Iliacus muscle and exterior cutaneous nerve. 3.—Genito-crural nerve.
4.—External iliac artery. 5.—External iliac vein. 6.—Bladder.

The compressor used by Mr. Davy consists of a lever of wood turned smooth and round, the small end to be applied over the common iliac artery, between the lumbar bodies and

psoas magnus muscle, on the diseased or injured side, while the projecting part of the lever runs parallel to the opposite thigh. Introducing the compressor into the rectum and elevating the projecting arm of lever, the perineal tissues are made to act as a fulcrum. As the lever is elevated or depressed, the femoral artery of that side ceases or continues to pulsate. A reference to the cut, for which I am indebted to my friend, Mr. Ernest Hart, will make any further description unnecessary. Mr. Davy believes that this method of controlling hemorrhage is less serious than compression of the aorta through the abdominal wall; that it is more easy and reliable; that the circulatory system is far less disturbed by reason of the circulation in the opposite limb being untouched; and finally, that this method of compressing aorta and iliacs, might apply to many operations in pelvic surgery. Mr. Davy has used his lever in a single case, and the loss of blood was about a wineglassful.

My next must be the last of my letters from here. I have the notes for many more, but lack the time to even string them together.

Faithfully, my dear Parvin,

D. W. YANDELL.

Clinic of the Month.

THE MICROSCOPIC EXAMINATION OF URINE.—At the October meeting, last year, I brought to the attention of this society the subject of the prevalence of unrecognized chronic Bright's disease. The existence particularly of a latent, preparatory, forming stage of the disease, in which no deviation from usual health occurs, and to which no recognized sign, no warning signal, is assigned, was pointed out in most striking, emphatic language, quoted from, and the concurrent testimony of, the best authorities. It was also shown by the same testimony, and it is well known to every practitioner, that the early progress and not unfrequently the course of chronic Bright's disease, is equally insidious and unrecognized.

If the urine of every person who consults or is seen by a physician were examined for albumen, and if albumen were invariably present in the urine of persons subjects of the disease to which the name albuminuria is given, then our art and practice would be sufficient and clear.

Grainger Stewart writes:—"Albumen is rarely present in any considerable quantity, and its presence fitful in its appearance and varying in its amount" in cirrhosis of the kidney.

"The simplicity of testing the urine for albumen, and so settling the question of the presence or absence of kidney disease, is so alluring, that many forget that it is only one symptom of renal disease." "The diagnosis of chronic renal disease during its quiescent periods (*that is, during the greater portion of its existence*)"—the italics are mine—"is a matter involving much thought and care, much knowledge and observation, watchful attention and thoughtful pathological research, ere an opinion entitled to any weight can be reached; and yet there are those who will at once decide the matter by

testing the urine for albumen, and if it be not present throw over forthwith all the other evidence—a plan calling for stern reprobation.” “The man who would make the diagnosis of chronic renal disease turn on the presence or absence of albumen, is a man whose patient I should not like to be.” “The silent progress of interstitial nephritis is often without albumen for long periods.” (Fothergill, “Hand-book of Treatment,” pp. 395–6.)

The professional experiences of the past year have added new examples of quickly fatal courses and terminations after late recognition in persons whose previous health was good, but who were subjects of chronic renal disease. In one of these the urine had been examined, and the absence of albumen had misled the physician in his diagnosis. In two others albumen was absent and the disease progressed unrecognized until the vision became suddenly impaired. Quite recently I have seen two persons whose health was good until about three months ago dyspnea, due to irregularity of the heart from associated hypertrophy, led to the investigation of the kidneys and the diagnosis of chronic renal disease. In these the urine gave all the usual evidences, in quantity, specific gravity, presence of albumen and renal tube-casts, of the disease. In several the only general form of cast found was the hyaline or transparent. This was uniformly the case in the examinations of the non-albuminous urines.

I therefore feel now more and more confirmed in the conclusion stated last October, “that the hyaline cast is a very early and important means of diagnosis—as early and significant in its relation to the kidney as the mucous râle is to the lung.”

I think in every stage of chronic Bright's disease the hyaline cast is present in the urine; and in those preparatory states of the circulatory, digestive and organs of secretion and excretion which lead in time to organic changes in the kidney, it will also be found. I do not propose, at this time, to enter upon an inquiry as to the importance of hyaline casts, or their significance when found in the urine. I do not suppose that

this or any other form of cast necessarily indicate structural disease of the kidney.

But whether albumen is or is not present, the microscopic examination is indispensable in any study of renal pathology. When hyperemia of the kidney exists, the hyaline cast will, I think, invariably show it, and often there is no other sign or symptom. If, in the absence of other signs and evidences, we may conclude that no important or permanent renal changes have taken place, still we should in every such case look for, and we shall often enough find, associated with the hyaline cast, as the primary cause of the renal hyperemia, valve disease or cardiac hypertrophy, atheromatous vessels, pulmonary emphysema, chronic pleuritic effusion, cirrhosis of liver, chronic catarrhs of bronchial, gastric or intestinal mucous membranes, stricture of the urethra, renal calculi, the gouty habit, chronic alcohol or lead poisoning, etc., together with many vague or so-called functional disturbances of the nervous, digestive, and other systems.

Regarded in this light, the hyaline has a daily and increasing practical value in my observations, not impaired by the fact to which I wish to give its proper recognition, that renal hyperemia, and so the hyaline cast, is most often as transient and insignificant as is the bronchial hyperemia of a common cold. In microscopical examination of urine of men in good ordinary health, in active life, with its vicissitudes dependent upon habits and pursuits, I have found one in four to have hyaline casts on one or more trials.

It has occurred to me so often to find renal tube casts in urine submitted to me for examination, when others, physicians practiced in the use of the microscope, have reported no casts in the same urine or in other urine from the same persons, that I wish to submit to the society the manner of my observations, so that those who are watching their patients and the families they attend for the earliest indications of renal affections, may, without too much expenditure of time, be certain that they have sufficiently sought for evidences afforded by the urine.

For, as is well known, the hyaline cast is not an abundant formation, compared with epithelial, fatty and granular casts, which are shed from the renal tubes in some forms of kidney disease as abundantly as the peeling after eruptive fevers. One or two hyaline casts are often all that can be seen after a well directed microscopic examination. Their transparency is spoken of as a reason why they are often overlooked. But I do not think, with the objectives at present offered by the best makers, it can be said there is any difficulty in seeing the so-called transparent casts.

It is the practice to take the portion for the microscopic slide with the pipette from the bottom of the urine. But urinary deposits are often *not* sediment, and I have many times taken portions from visible deposits floating near the surface or at various depths below, and found casts when the pipette, passed to the bottom, obtained none. Quite recently a member of our profession in the city of New York, of middle age, in apparent good health, who suffered a few months ago a slight impairment of vision, and then discovered that his urine contained albumen and had a specific gravity of 1008, sought the advice of a distinguished consulting physician, who recognized the facts so far as related, but did not find any casts. In the urine submitted to me, after standing eighteen hours, I saw a light cloud floating in the urine near the surface. This contained numerous casts, but none were found from the bottom.

Again, casts may not be found in the sediment after six hours' standing, when the sediment of the same urine after twelve hours more may yield them. When the microscopic examination of a single drop has failed me, a second or third, or some successive search, has repaid the expenditure of time. (B. A. Segur, M. D., in Proceedings of the Medical Society of the County of Kings, October, 1878.)

THE CASUAL RELATION BETWEEN URTICARIA AND MALARIA.
In the *Memorabilien*, September 18, 1878, Dr. Kersch presents a case—novel to him, but familiar to many of our readers—

which resisted treatment for some time, that of a married woman forty-one years old, suffering from malarial fever, from which urticaria resulted. On examination he found the liver and spleen enlarged, pulse 112, temperature 38° Cent., about $100\frac{1}{2}^{\circ}$ F. Quinia was administered, and the next morning the patient felt much better, but in the evening there was a return of the fever. Quinia was ordered again and the fever disappeared; but on visiting the patient a few days after, she informed the doctor that during the past night she was very restless on account of a continual itching of the back and arms and of the whole body, so that she had slept very little. There was an eruption of the skin of a dark red color, which looked as if the patient had been bitten by bed-bugs or some other insect, and the conclusion was reached that it was a case of intense urticaria. Dr. K. informed the woman that he was mistaken in his previous diagnosis; that it was a case of urticaria, (for although he had often heard of urticaria following malaria, he had never seen a case), and comforted her with the prognosis that it would disappear in four or five days, at the same time restricting the quinia to one half the amount he had been giving. Eleven days passed, and the promised disappearance of the exanthem did not occur, in spite of the use of carbolyzed glycerine, baths, ointments, etc.

The patient became discouraged, and Dr. Pick, lecturer on dermatology and syphilis, was called in consultation, who at once suggested the possible connection of the eruption with malaria, and recommended large doses of quinia for a long time. The patient took, twice a day for fifteen days, a half gram of quinia, without any positive result, except controlling the fever. The patient was then ordered one gram of quinia in the morning and a half gram at noon; and at my evening visit she complained greatly of cinchonism, loss of hearing, etc., but I heard nothing more of the itching, there being not a trace of the exanthem left. The state of the temperature and pulse in this case was interesting; the body was cool, the temperature being 34.8° Centigrade or $94\frac{3}{8}^{\circ}$ F., the pulse 52 per minute.

ACUTE CEREBRAL ANEURISM—OCULO MOTOR PARALYSIS—MENINGEAL APOPLEXY.*—The patient was a girl aged seventeen years, of phthisical family, delicate, tall and slender, very thin, of fair complexion, but hitherto in good health. While having a difficult evacuation from the bowels, during which there was much straining, she suddenly felt as if something had given way within the head, somewhere above the right eye. This was followed by a circumscribed headache, which continued uninterrupted ever since. She subsequently had periodical vomitings; the bowels moved sluggishly, and there was slight fever. When examined a few days later she had divergent strabismus and ptosis of the right eye; both pupils were somewhat large. The pulse was 64 to the minute.

The treatment consisted of cold applications, laxatives, ice, and morphia internally. Ptosis became more marked; three days later she could not open the eye; the eyeball was immovable in its abnormal position, and the right pupil considerably dilated and motionless.

During the following two weeks there was very little change. Scarcely any amelioration in the headache; the fever ceased, pulse varied from 72 to 80. Vomiting occurred at longer intervals; bowels moved naturally. She now began to sit up a little.

Prognosis very grave. The family was given to understand that the disease might at any time culminate in a sudden and unfavorable manner, which actually happened a little over a month after the first examination. She rose in the morning, vomited a couple of times as usual, and lay down on the bed during the forenoon; then without any prodromata she became unconscious, there was cyanosis, spasms of the extremities, and the mouth was drawn to the right side. When the physician arrived, half an hour later, she was dead.

Sectio cadaveris.—The whole subdural and subarachnoid space over the convexity, and at the base of the brain, was filled with dark and coagulated blood; the extravasation ex-

* Translated from *Nordiskt Medicinskt Archiv*, by JOHN A. OCTERLONY, A. M., M. D.

tended down into the spinal cord. An aneurism, the size of a large pea, was found arising by a pediculated attachment from the intracranial portion of the internal carotid, at a point between the origin of the anterior cerebral and the posterior communicating arteries, close to the entrance of the third nerve into the cavernous sinus. On the outer aspect the aneurism was covered, as with a capsule, by the flattened third nerve. On the cerebral aspect was an opening infiltrated with blood. The arterial wall at the origin of the aneurism was much attenuated. No embolus could be found anywhere. The right middle cerebral artery was considerably wider than the left, but without any degeneration of its walls. Nothing else to be observed except anemia of the eyeballs. The cranial cavity alone could be examined.

The sudden accession of extended yet sharply limited local phenomena led to a somewhat positive diagnosis, especially as aneurism at the base of the brain occurs not seldom and at all ages; while a neoplasm (latent up to the time of seizure), or apoplexy, in this locality, that is close to the trunk of the oculo motor nerve, was hardly probable. The sensation of sudden giving way within the head, and the other circumstances attending the commencement of her illness, speak in favor of an incomplete rupture of the arterial wall, determined by a greatly increased intracranial blood pressure and consequent dilatation of the weakened vascular wall. The other cerebral arteries were perfectly sound, as one would expect in so young a person. The final meningeal apoplexy was due to rupture of the aneurism according to the usual course.

SYPHILITIC DISEASE OF THE LIVER.*—The patient, a maid of twenty-five years, had always been sickly; when ten years old she had ulcers in the throat and on the trunk; at the age of sixteen years she was treated for inflammation of the kidneys. Four years ago she again had ulcers in the throat and

*Translated from *Nordiskt Medicinskt Archiv*, by JOHN A. OCTERLONY, A. M., M. D.

on the lower extremities, which slowly healed under anti-syphilitic treatment. In September, 1876, her feet began to swell, and during the summer of 1877 the swelling extended to the abdomen and other parts of the body, and soon became very considerable. In September, 1877, when she entered the Seraphim Hospital at Stockholm, she had general anasarca; the lower extremities were enormously swollen, and she also had considerable ascites. The lower border of the liver could not be accurately determined by percussion, and it could not be felt on palpation. The urine contained a great deal of albumen and numerous tube-casts of different kinds. There was considerable loss of substance in the throat and of the soft palate, and the uvula was entirely gone. Several superficial cicatrices on the legs. The urine became very scanty during her stay in the hospital, and on the 8th of October she had a sudden attack of uremia with coma, and violent convulsions followed by diarrhea and repeated vomiting. After this her strength rapidly failed, and she died on the 21st of October.

At the autopsy were found the throat lesions, recognized during life and attributed to syphilis. There was also found a hyperplastic nephritis and splenitis. The liver was attached to the diaphragm by firm adhesions. The organ was strongly nodulated on the surface, with deep cicatrix-like depressions between the nodules. Section of the liver showed it to be permeated by a very large number of typical gummata. In one section were seen at least fifteen; the largest of them having a diameter of four centimeters. A great many were evidently of recent origin, and were presumably in the period of active growth. It was remarked by Prof. Key that he had never before seen a liver with such a large number of gummata; they were estimated to be over fifty, and he had hardly ever seen them so large. It is a point of special interest that in this case, where during the first half of the decennium 20-30, such an unusually abundant irruption of hepatic gummata took place. Syphilis very plainly was either hereditary, or acquired during early childhood.

Notes and Queries.

THE MEDICAL COMMISSION.—The government has appointed a committee, consisting of three medical men, for the purpose of studying the march and progress of the present yellow fever epidemic. The gentlemen composing the committee are Professor Bemiss, of New Orleans, chairman; Professor Cochran, of Mobile; and Professor Howard, of Baltimore. The selection will certainly inspire the profession throughout the country with confidence. It only remains to be seen whether the labors of the commission will increase our present very meager and unsatisfactory knowledge of the fever. Let us hope that the committee will enter upon the work with minds fallow for the reception of truth, no matter whence it may come, or what shape it may take. If they do not their labor will be vain, and another opportunity to clear up what has hitherto seemed to be the almost impenetrable mystery which surrounds the march of yellow fever, will have been lost.

Let us hope, whatever may have been their opinions, that when they accept the responsibilities of the commission, they will leave these at the door, and bring to their momentous task minds virgin to truth. If they can not do this, they are not fit for the work. If they begin their investigations believing that the poison of yellow fever is communicated by contact from person to person, or is transported from point to point on water or on land, or that it is developed as the result of certain hydrometric and thermometric conditions, and in view of facts are not able to divest themselves of these opinions, they shall prove unworthy the honor they have won, and their labors will end in confusion. No commission ever appointed by this government has had such momentous issues

placed in its hands. If it solve the problem of the rise and spread of yellow fever, it will win, not only the homage of the profession, but the gratitude of mankind as well.

FOUNTAIN COUNTY MEDICAL SOCIETY.—The following is an extract from the transactions of this society at its semi-annual meeting, held at Veedersburg, Ind., October 3, 1878:

Dr. G. S. Jones, president, in the chair; Dr. J. C. Burlington, of Attica, was admitted a member of the society; total number of members, twenty-two.

Dr. S. J. Irwin, of Crawfordsville, Ind., read a paper entitled "A plea for an anatomical law in Indiana," in which he condemned, in the strongest terms, the practice of stealing human bodies, and expressed the desire that all body-snatchers should be apprehended and punished. He said that the late agitation upon that subject might prove a Godsend to the medical profession, as it would bring prominently before the mind of the public the inconsistency of the present law, which, while it requires of the physician a thorough knowledge of human anatomy, deprives him of the only means of obtaining it. He thought the law of New York a good one, which allows the bodies of unclaimed persons who die in the hospitals, and of criminals, to be handed over to the doctors for dissection.

The following resolutions were presented and adopted:

Resolved, That it is one of the most important duties of our State Legislature, however much it has been neglected heretofore, to enact suitable laws to secure to the people all possible benefits from sanitary science in protection from contagious, epidemic and endemic disease; and this society believes that the establishment of State and Local Sanitary Boards would be an important step in that direction.

Resolved, That the state should take cognizance of the qualifications of physicians, in order to protect the health and lives of the people from danger by unskillful treatment, by providing a State Board of Medical Examiners, and making it a penal offense to practice medicine without a certificate of qualification from said Board. The said Board of Examiners should require a thorough knowledge of all the branches of medical science as usually taught, without regard to school (sect), or individual theories.

Resolved, That this society earnestly recommend and request our representatives in the State Legislature to favor the passage of suitable laws, permitting and encouraging the study of practical anatomy by physicians and medical students.

Resolved, That the secretary be requested to furnish a copy of these resolutions to Dr. G. S. Jones, who was appointed by the State Society to represent Fountain county on a committee "to use their influence with the Legislature" in this matter, and to the newspapers of the county for publication.

T. F. LEECH, M. D., Secretary.

HOW DOCTORS DISAGREE.—In the Philadelphia Medical Times, September 28, 1878, appears a review of "Hamilton on Nervous Diseases," which throughout is rather complimentary. It says:—"A need has existed for a book on nervous diseases, clear, compact, comprehensive, and up to the times. This has been largely met by Dr. Hamilton's volume. On the whole, after a careful reading of this book, we can commend it to the general practitioner and student as the work most likely to meet their requirements."

In the September number of the St. Louis Clinical Record is a review of the same book, which is very uncomplimentary, from which we make the following extract:—"We have taken the trouble to wade through Dr. Hamilton's book, and with a full sense of our responsibility to our readers, we do not hesitate to say, that we have not found in it a single idea of the author's which is original and worth the paper on which it is printed. We are very sure there is not a neurologist, in this or any other country, who will not agree with us that the volume is, in the main, an undigested mass of material taken bodily, in most cases without acknowledgment, from recently published works on diseases of the nervous system; and that what is not thus unlawfully gathered into Dr. Hamilton's garner is scanty, worthless, incorrect or unreliable."

It is possible that neither of these reviews represents the book fairly; but if the Record, after its severe review, is so critical as to correct many of the typographical errors of proper names, it certainly should not fall into the pit it has dug for Dr. Hamilton, by saying that *Freidreich* is called

Friedrich, which latter way of spelling Friedreich it classes among the "minor but still aggravating mistakes, or exhibitions of ignorance."

IODINE IN INTERMITTENT FEVER.—In the Cincinnati Lancet and Clinic, July 27th and August 31st, favorable comment is made on the recommendation of a Russian with the formidable name, Nowodnitschauski, that tincture of iodine is very efficacious in ague. What's the necessity of introducing us to this long-named foreigner, when Dr. James Y. Shearer told the readers of the Reporter the same thing nigh five years ago (January, 1874); and, before him, in 1871, Dr. Napheys had said the same, in the third edition of his Modern Therapeutics? Let us credit those of our own household when we can. (Medical and Surgical Reporter.)

For a notice of this use of iodine, see the Western Journal of Medicine, August, 1869, two years in advance of the utterance of Dr. Napheys. "Let us credit those of our own household when we can."

ERRATUM.—In Dr. Thornberry's article in last month's issue, the symptoms almost pathognomonic of malarial remittent should be tenderness of the spleen with *indented* tongue, instead of *indurated* tongue.

LONG DIVISION AND SUBTRACTION.—In the last number of our journal Dr. Yandell's letter was by mistake divided into two parts, and the second part, occupied with Spencer Wells's lectures, placed at quite a distance from the first—a distance both long and wrong. So, too, Dr. Yandell's signature was omitted—a mistake of subtraction.